JEFFERSON COUNTY
HUMAN SERVICES DEPARTMENT

SERVING THE RESIDENTS OF JEFFERSON COUNTY

2015
ANNUAL REPORT

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JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
Serving the Residents of Jefferson County
1541 Annex Rd, Jefferson, WI 53549-9803
Phone: 920-674-3105 Fax: 920-674-6113

April, 2016

Dear County Board Chair,
Members of the Jefferson County Board of Supervisors,
Members of the Jefferson County Human Services Board,
Jefferson County citizens and other interested parties,

RE: Letter from the Director

It is my privilege to share with you the Jefferson County Human Services Department annual report. We continue as a Department to use performance measures to drive our services and deliver beneficial results for our citizens. You will find, immediately following, a chart summarizing the Key Outcome Indicator for each team in each division. We define a key outcome indicator as the number one measure of what we are trying to accomplish. I am pleased to report that almost all were accomplished in 2015.

Moving into this year, the Department continues to respond to the challenges our citizens face. I hope you read the in-depth information provided in this report as the work we do continues to grow in complexity.

In 2016:

- Our Administrative Services Division will provide fiscal oversight to the Department and assure compliance with all county, state and federal guidelines.

- The Aging and Disability Resource Division will provide effective services for persons with disabilities and people over the age of sixty. We will become the first dementia friendly county government.

- The Behavioral Health Division will deliver evidence based treatment programs in a person centered and recovery focused manner. We will continue to provide a range of options for people with opioid addictions.

- The Child and Family Division will assure the safety, permanence, and well-being of children while remaining family based. We will continue to find options for families when parents are challenged with addiction issues.

- The Economic Support Division will provide access to resources for citizens and, in partnership with the Southern Income Maintenance Consortium, will provide the entry into the Accountable Care market exchanges as well as determining Medicaid eligibility.

I abundantly thank our County Board Supervisors and the members of our Human Services Board for their ongoing support. I humbly thank and recognize our devoted staff, who continue to provide high quality and efficient services. Thank you.

Respectfully submitted,

Kathi Cauley
Director,
Jefferson County Human Services

Mission Statement

To enhance the quality of life for individuals and families living in Jefferson County by addressing their needs in a respectful manner and enabling citizens receiving services to function as independently as possible while acknowledging their cultural differences.

Vision Statement

All citizens have the opportunity to access effective and comprehensive human services in an integrated and efficient manner.

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
ADMINISTRATION			
Fiscal	Accurately complete all county, state, and federal reports and billing	State and Federal budget acts Numerous Compliance laws All Medicaid and Medicare requirements	100% compliance with reporting requirements as denoted on work chart
Maintenance	Maintain buildings and grounds while planning for future	46	100% of capital projects completed on time and within budget
AGING & DISABILITY RESOURCE CENTER (ADRC)			
ADRC	A one-stop shop providing accurate, unbiased information on all aspects of life related to aging or living with a disability; and serves as the access point for publicly-funded long term care.	46.283, DHS 10	100% compliance with the State contract
Adult Protective Services and Elder Abuse	Vulnerable adults, aged 18+ are aware of and have access to Adult Protective Services 24/7	46.283, 46.90, 51, and 55	100% of referrals are responded to within the time frames contained in the statute; and case notation and legal time frames are met in 100% of cases referred.
Senior Dining Program	Serve & deliver, without interruption, well-balanced meals to seniors who request them in our service area, and to those who have the greatest economic or social need	Older American's Act (OAA)	95% of qualifying individuals who request home delivered meals receive them.

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Transportation	Provides medical transportation to seniors and persons with disabilities and rides to department appointments.	85.21	100% of qualifying individuals who request a ride receive one.
BEHAVIORAL HEALTH DIVISION			
Community Support Program	Integrated services for people with severe and persistent mental illness	51 AR 63	72% of all treatment plan goals are met
Community Recovery Services	Residential services for people with mental health and substance abuse	51	100% compliance with CRS rules
Comprehensive Community Services	Recovery based community, mental health, and substance abuse services	Supports 51 services AR 36	72% of all treatment plan goals are met
Emergency Mental Health	24/7 mobile response to all crisis call	51	Giving consideration to lethality and acuity, maintain diversion rate to least restrictive setting
Outpatient Alcohol and Other Drugs Clinic	Treatment services for substance use including opioid addictions	75	Decrease Brief Alcohol Monitoring Scores
Outpatient Mental Health Clinic	Provide mental health counseling	51 AR 35	PQH 9 score will improve by 2%
CHILD & FAMILY DIVISION			
Birth to Three	Supporting Families in promoting the growth and development of their children.	46 and 51 AR 910	The Birth to Three Program will be issued a notification of 100% compliance with the Federally Compliancy Indicators by DHS based on the annual data review.
Busy Bee Pre-School	Supporting Families in promoting the growth and development of their children.	46 and 51 AR 910	Busy Bees Pre-School will maintain a 4-star rating from the YoungStar Program.

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Children in Need of Protective Services	Monitor safety, well-being, and permanence for all children found to be in need of protection or services by the courts.	48	All new out-of-home placements will be formally screened for permanency options within 90 days of case assignment to ongoing staff.
Children Long Term Support/CST	Multi-disciplinary approach to building community based MA funded programing for youth.	46	90% of all children will remain in their home with the use of CLTS and CST services
Independent Living	Enhancing daily living skills for youth in placement to transition to adulthood successfully.	48	90% of IL youth and young adults who have aged out of care will enroll in the military, work program or secondary education program.
Intake	Provides a single access point for all child, juvenile and family service needs.	48, 938	100% of all State and Federal timelines will be met
Juvenile Justice Integrated Services	Provide evidence based treatment and supervision to all court ordered youth.	938	95% of children on formal supervision will remain in the community through the use of community based safety plans and treatment
ECONOMIC SUPPORT DIVISION			
Child Care	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards
Energy Assistance	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards
Foodshare-Food Stamps	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards
Medical Assistance and Market Place exchanges	Facilitates access for those who are eligible	46, 49 and PPACA	Meet mandated performance standards

HUMAN SERVICES BOARD OF DIRECTORS
2015 – 2016

Jim Mode, *Chair*

Richard Jones, *Vice Chair*

John McKenzie, *Secretary*

Cynthia Crouse

Russell Kutz

Augie Tietz

James Schultz

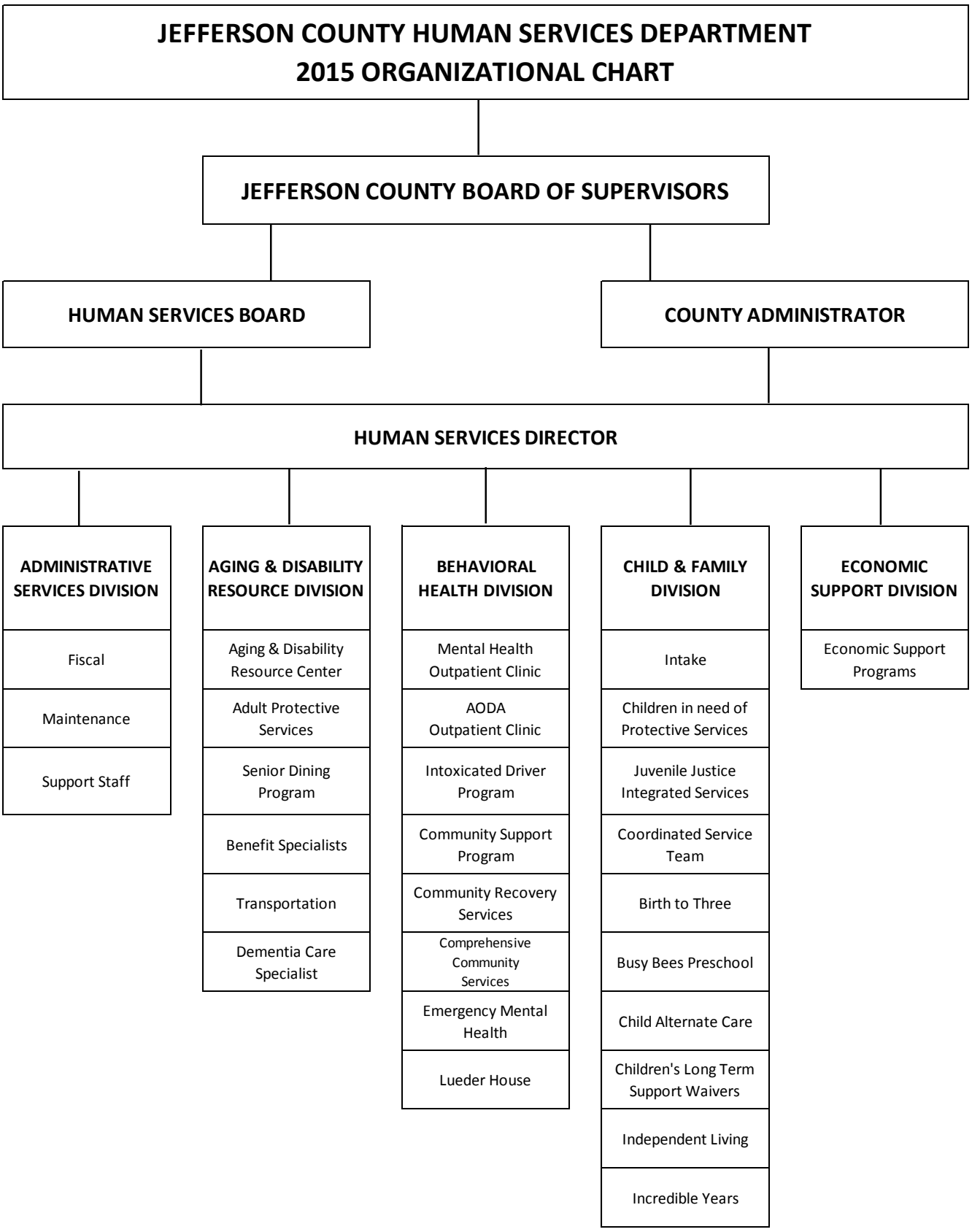
AGING AND DISABILITY RESOURCE CENTER ADVISORY COMMITTEE

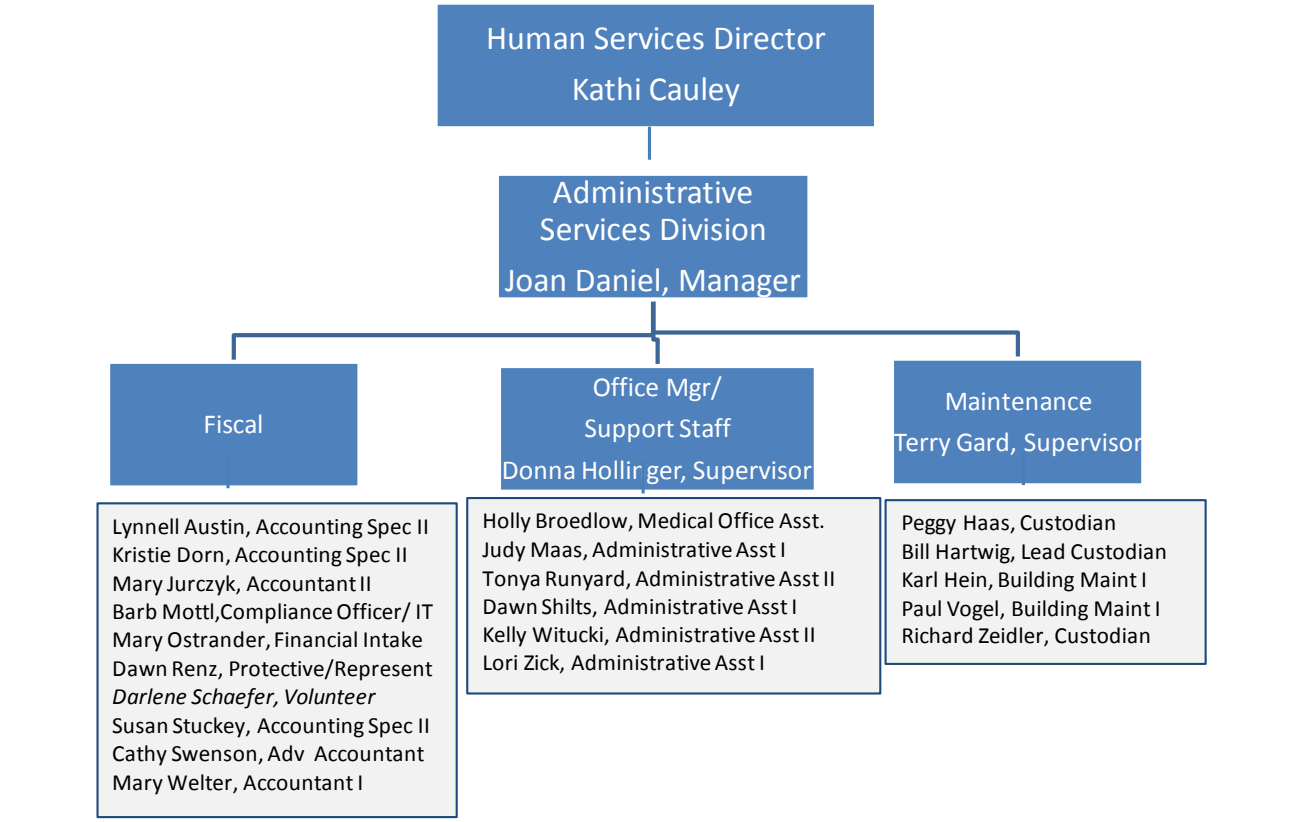
Earlene Ronk, Chair
Carol Battenberg
Ellen Haines
Dan Krause
Russell Kutz, Vice Chair
Jim Mode
Carolyn Niebler, Secretary
Darlene Schaefer
Connie Stengel
Sue Torum, Staff
Sharon Olson, Staff

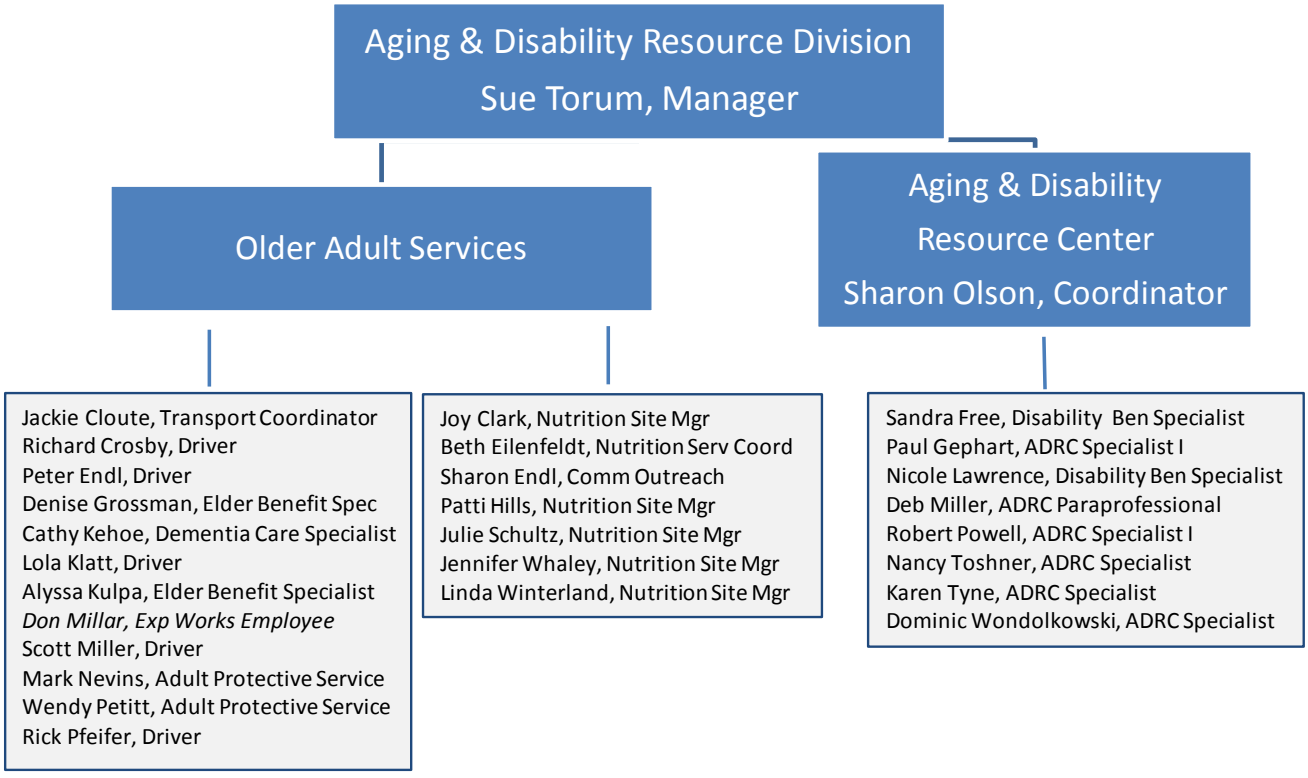
NUTRITION PROJECT COUNCIL

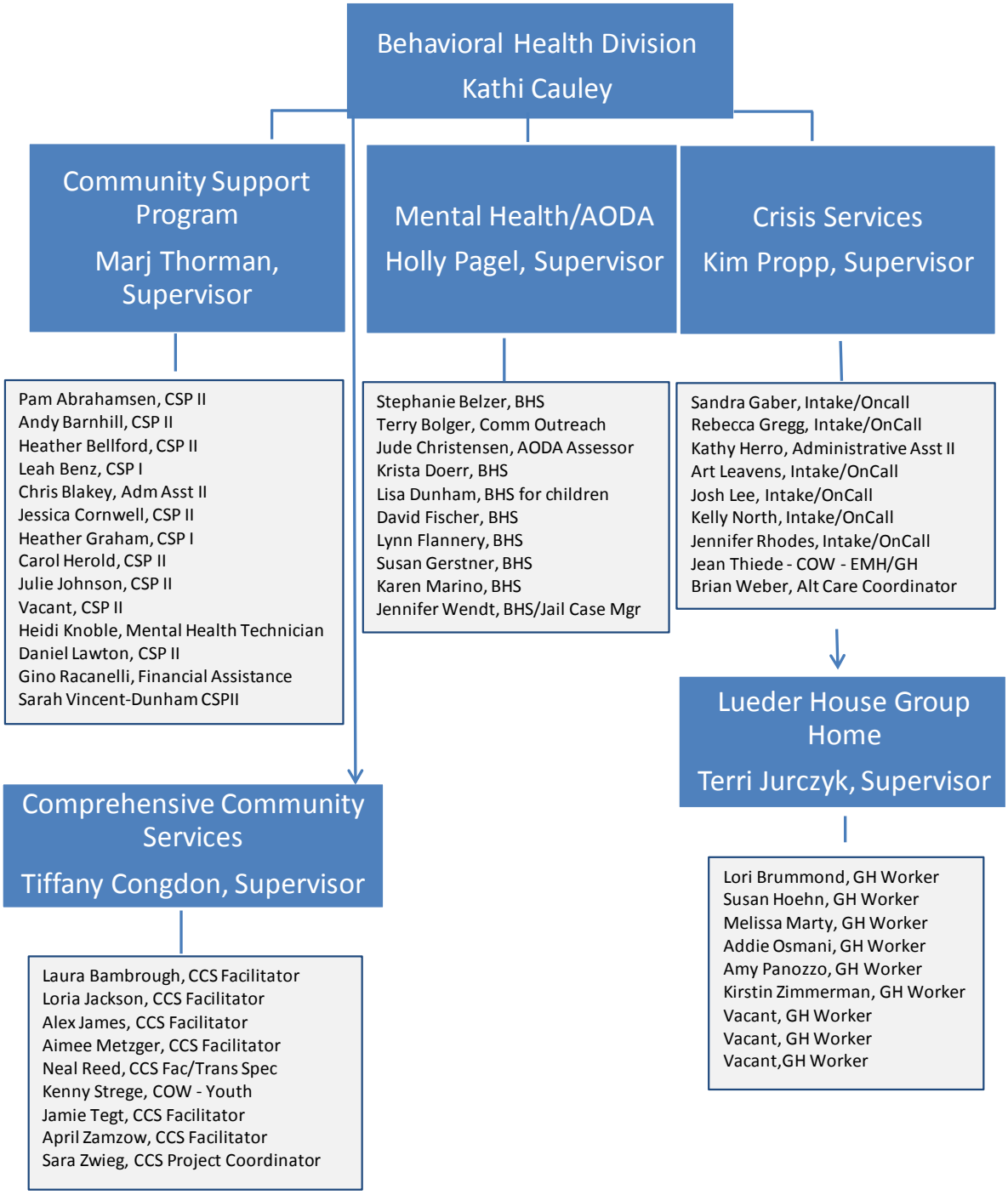
Karen Anfang
Carol Ellingson
Janet Gerbig
Holly Ingersoll
Rita Kannenberg
Cheryl Langlois
Barbara Natrop
Emily Pantely

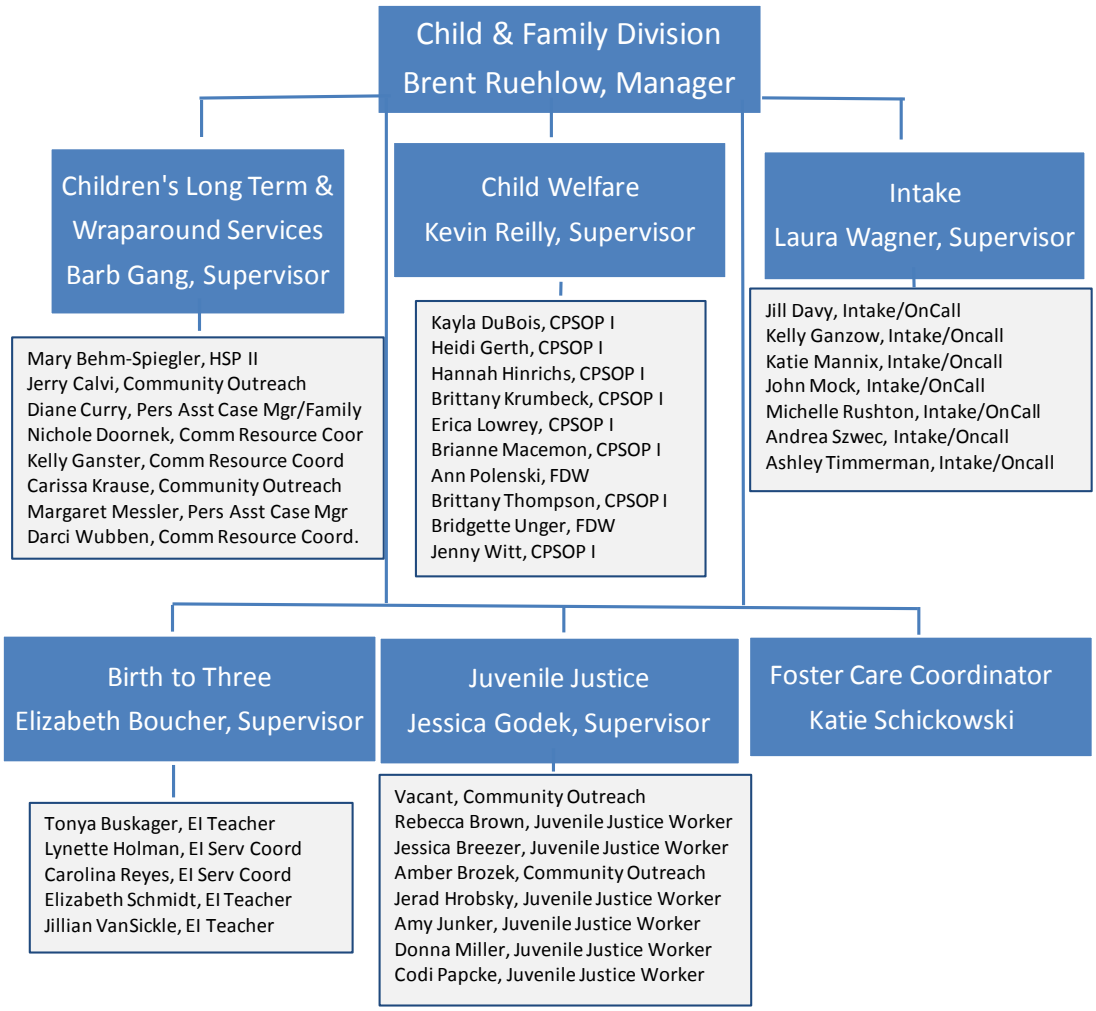
JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
2015 ORGANIZATIONAL CHART

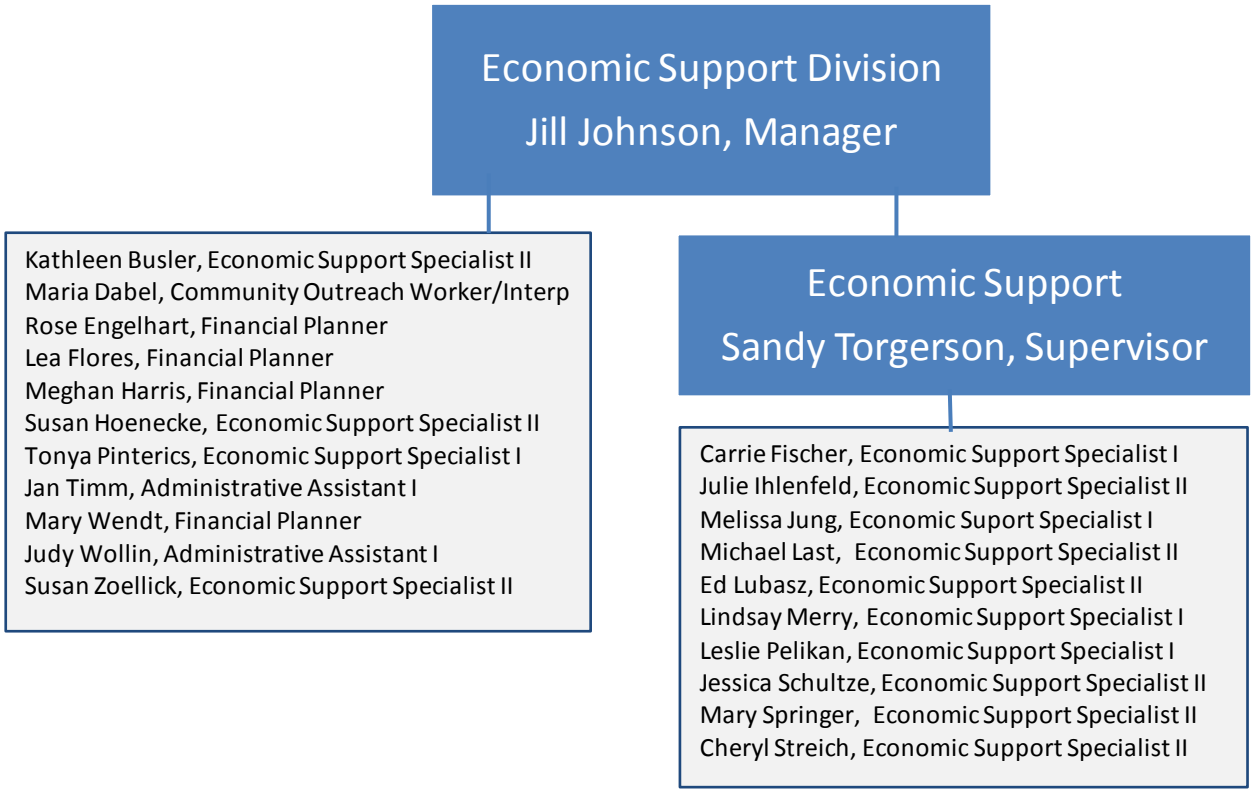



Human Services Director
Kathi Cauley
Administrative Services Division
Joan Daniel, Manager
Fiscal
Office Mgr/ Support Staff
Donna Hollir ger, Supervisor
Maintenance
Terry Gard, Supervisor
Lynnell Austin, Accounting Spec II
Kristie Dorn, Accounting Spec II
Mary Jurczyk, Accountant II
Barb Mottl,Compliance Officer/ IT
Mary Ostrander, Financial Intake
Dawn Renz, Protective/Represent
Darlene Schaefer, Volunteer
Susan Stuckey, Accounting Spec II
Cathy Swenson, Adv Accountant
Mary Welter, Accountant I
Holly Broedlow, Medical Office Asst.
Judy Maas, Administrative Asst I
Tonya Runyard, Administrative Asst II
Dawn Shilts, Administrative Asst I
Kelly Witucki, Administrative Asst II
Lori Zick, Administrative Asst I
Peggy Haas, Custodian
Bill Hartwig, Lead Custodian
Karl Hein, Building Maint I
Paul Vogel, Building Maint I
Richard Zeidler, Custodian


Aging & Disability Resource Division
Sue Torum, Manager
Older Adult Services
Aging & Disability Resource Center
Sharon Olson, Coordinator
Jackie Cloute, Transport Coordinator
Richard Crosby, Driver
Peter Endl, Driver
Denise Grossman, Elder Benefit Spec
Cathy Kehoe, Dementia Care Specialist
Lola Klatt, Driver
Alyssa Kulpa, Elder Benefit Specialist
Don Millar, Exp Works Employee
Scott Miller, Driver
Mark Nevins, Adult Protective Service
Wendy Petitt, Adult Protective Service
Rick Pfeifer, Driver
Joy Clark, Nutrition Site Mgr
Beth Eilenfeldt, Nutrition Serv Coord
Sharon Endl, Comm Outreach
Patti Hills, Nutrition Site Mgr
Julie Schultz, Nutrition Site Mgr
Jennifer Whaley, Nutrition Site Mgr
Linda Winterland, Nutrition Site Mgr
Sandra Free, Disability Ben Specialist
Paul Gephart, ADRC Specialist I
Nicole Lawrence, Disability Ben Specialist
Deb Miller, ADRC Paraprofessional
Robert Powell, ADRC Specialist I
Nancy Toshner, ADRC Specialist
Karen Tyne, ADRC Specialist
Dominic Wondolkowski, ADRC Specialist


Behavioral Health Division
Kathi Cauley
Community Support Program
Marj Thorman, Supervisor
Mental Health/AODA
Holly Pagel, Supervisor
Crisis Services
Kim Propp, Supervisor
Pam Abrahamsen, CSP II
Andy Barnhill, CSP II
Heather Bellford, CSP II
Leah Benz, CSP I
Chris Blakey, Adm Asst II
Jessica Cornwell, CSP II
Heather Graham, CSP I
Carol Herold, CSP II
Julie Johnson, CSP II
Vacant, CSP II
Heidi Knoble, Mental Health Technician
Daniel Lawton, CSP II
Gino Racanelli, Financial Assistance
Sarah Vincent-Dunham CSPII
Stephanie Belzer, BHS
Terry Bolger, Comm Outreach
Jude Christensen, AODA Assessor
Krista Doerr, BHS
Lisa Dunham, BHS for children
David Fischer, BHS
Lynn Flannery, BHS
Susan Gerstner, BHS
Karen Marino, BHS
Jennifer Wendt, BHS/Jail Case Mgr
Sandra Gaber, Intake/Oncall
Rebecca Gregg, Intake/OnCall
Kathy Herro, Administrative Asst II
Art Leavens, Intake/OnCall
Josh Lee, Intake/OnCall
Kelly North, Intake/OnCall
Jennifer Rhodes, Intake/OnCall
Jean Thiede - COW - EMH/GH
Brian Weber, Alt Care Coordinator
Lueder House Group Home
Terri Jurczyk, Supervisor
Lori Brummond, GH Worker
Susan Hoehn, GH Worker
Melissa Marty, GH Worker
Addie Osmani, GH Worker
Amy Panozzo, GH Worker
Kirstin Zimmerman, GH Worker
Vacant, GH Worker
Vacant, GH Worker
Vacant,GH Worker
Comprehensive Community Services
Tiffany Congdon, Supervisor
Laura Bambrough, CCS Facilitator
Loria Jackson, CCS Facilitator
Alex James, CCS Facilitator
Aimee Metzger, CCS Facilitator
Neal Reed, CCS Fac/Trans Spec
Kenny Strege, COW - Youth
Jamie Tegt, CCS Facilitator
April Zamzow, CCS Facilitator
Sara Zwieg, CCS Project Coordinator


Child & Family Division
Brent Ruehlow, Manager
Children's Long Term & Wraparound Services
Barb Gang, Supervisor
Mary Behm-Spiegler, HSP II
Jerry Calvi, Community Outreach
Diane Curry, Pers Asst Case Mgr/Family
Nichole Doornek, Comm Resource Coor
Kelly Ganster, Comm Resource Coord
Carissa Krause, Community Outreach
Margaret Messler, Pers Asst Case Mgr
Darci Wubben, Comm Resource Coord.
Child Welfare
Kevin Reilly, Supervisor
Kayla DuBois, CPSOP I
Heidi Gerth, CPSOP I
Hannah Hinrichs, CPSOP I
Brittany Krumbeck, CPSOP I
Erica Lowrey, CPSOP I
Brianne Macemon, CPSOP I
Ann Polenski, FDW
Brittany Thompson, CPSOP I
Bridgette Unger, FDW
Jenny Witt, CPSOP I
Intake
Laura Wagner, Supervisor
Jill Davy, Intake/OnCall
Kelly Ganzow, Intake/Oncall
Katie Mannix, Intake/Oncall
John Mock, Intake/OnCall
Michelle Rushton, Intake/OnCall
Andrea Szwec, Intake/Oncall
Ashley Timmerman, Intake/Oncall
Birth to Three
Elizabeth Boucher, Supervisor
Tonya Buskager, EI Teacher
Lynette Holman, EI Serv Coord
Carolina Reyes, EI Serv Coord
Elizabeth Schmidt, EI Teacher
Jillian VanSickle, EI Teacher
Juvenile Justice
Jessica Godek, Supervisor
Vacant, Community Outreach
Rebecca Brown, Juvenile Justice Worker
Jessica Breezer, Juvenile Justice Worker
Amber Brozek, Community Outreach
Jerad Hrobsky, Juvenile Justice Worker
Amy Junker, Juvenile Justice Worker
Donna Miller, Juvenile Justice Worker
Codi Papcke, Juvenile Justice Worker
Foster Care Coordinator
Katie Schickowski


Economic Support Division
Jill Johnson, Manager
Kathleen Busler, Economic Support Specialist II
Maria Dabel, Community Outreach Worker/Interp
Rose Engelhart, Financial Planner
Lea Flores, Financial Planner
Meghan Harris, Financial Planner
Susan Hoenecke, Economic Support Specialist II
Tonya Pinterics, Economic Support Specialist I
Jan Timm, Administrative Assistant I
Mary Wendt, Financial Planner
Judy Wollin, Administrative Assistant I
Susan Zoellick, Economic Support Specialist II
Economic Support
Sandy Torgerson, Supervisor
Carrie Fischer, Economic Support Specialist I
Julie Ihlenfeld, Economic Support Specialist II
Melissa Jung, Economic Suport Specialist I
Michael Last, Economic Support Specialist II
Ed Lubasz, Economic Support Specialist II
Lindsay Merry, Economic Support Specialist I
Leslie Pelikan, Economic Support Specialist I
Jessica Schultze, Economic Support Specialist II
Mary Springer, Economic Support Specialist II
Cheryl Streich, Economic Support Specialist II

ADMINISTRATION SERVICES DIVISION

"Providing support, maintenance and fiscal oversight to the Department"

The Administrative Services Division provides fiscal, maintenance, and support oversight for the department; these three sections are overseen by a division manager.

The **Fiscal team** consists of nine full time employees, and one volunteer. They ensure that all accounting, billing for client insurance, protective payee payments, client financial ability to pay reviews, data tasks, and all financial reports are accomplished for the department.

The **Maintenance team** consists of a supervisor, four full time employees and two part time employees. They ensure that the vehicles, buildings and grounds are in working order, and capital projects are completed within budgetary guidelines.

The **Support Staff team** consists of an Office Manager/Supervisor, six full time employees, and two part time staff who are employed through Experience Works. They ensure that phones are answered, appointments are scheduled, records are maintained and filed, and all other support duties are completed.

FISCAL

~ Ensuring fiscal responsibility to the citizens of Jefferson County~

Fiscal Statement Summary
December Final, 2015
(Unaudited)

We had a positive fund balance of $1,208,814 at the end of the year. There were $247,487 in prepaid assets on the balance sheet for 2015 expenditures. Operations had a favorable balance of $532,981. Our non-lapsing request of $992,258 was approved leaving a balance of $216,556 that was returned to the County General Fund.

Major Classifications that impacted the favorable 2015 balance

Summary of Variances:

Federal/State & Operating Revenue: Overall Revenues were unfavorable by $68,527

Expenditures: Overall Expenditures were favorable by $1,035,311

Children Long Term Support (CLTS) was under budget by $348,896: The state issued a contract for Children's Long Term Support (CLTS) program for 2014/2015. This contract was for children who were on the CLTS wait list. Since children are placed through the year, a partial year was paid for some the clients in 2015. Once a child is placed on CLTS, the child can't be removed from the program based on funds available. To ensure that 2016 funds were available on an annualized basis we did not capture the full state contract by $389,896.

Children Alternate Care was over budget by $342,178: This budget includes Alternate Care, Child Caring Institutions, Detentions, and Correctional Facilities and Shelter Care. The primary reason for the overrun in 2015 is due to placing unforeseen high needs children at higher cost facilities.

Hospital/Detox was under budget by $255,116 (on net basis): This occurred primarily because $1,356,466 in expenditures was budgeted and $999,777 was spent. We are also reimbursed by the state institues after insurance pays in revenue. This is shown below in the table.

Hospital/Detox projection is under budget by $255,116 (Net basis):

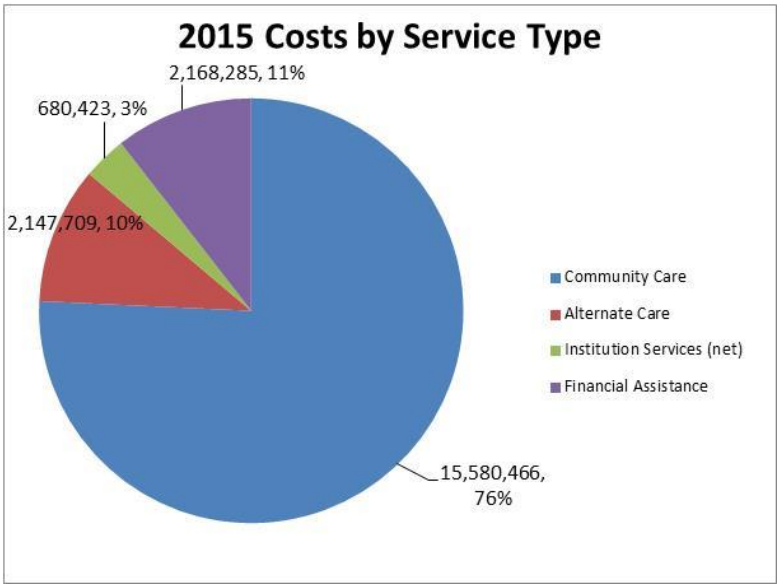
	Budget	Actual	Variance
Revenue	**513,817**	**412,244**	**101,573**
Expenditures	**1 ,356,466**	**999,777**	**-356,689**
Net	**842,649**	**587,533**	**-255,116**

Salary & Fringe was under budget by $270,913: This is due to vacancies due to turnover and employees on family leave. In addition, some of the new positions were in the process of being recruited at the beginning of 2015.

Capital Outlay was under budget by $146,244: The Echo project is still in process and will carryover to 2016. The non-lapsing request for Echo is $111,770 and the pre-paid portion is $58,851 totaling $170,621 carry forward into 2016. This was approved by the Board. The Lueder House generator project was finalized in 2016 in the amount of $40,000. This expense was also approved by the Board to carry forward.

Total Expenditures		
Community Care	15,580,466	75.72%
Alternate Care	2,147,709	10.44%
Institution Services (net)	680,423	3.31%
Financial Assistance	2,168,285	10.54%
TOTAL	20,576,883	100.00%

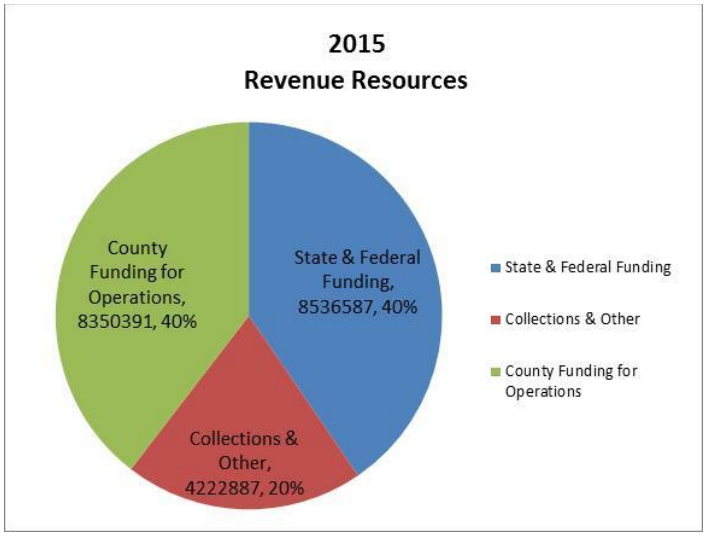
(does not include Depreciation & County Indirect Cost in pie chart)



In 2015 actual costs increased in expenditures by $1,292,849 from 2014 which is a 6.7% increase for the department. Alternate Care increased by 19.44% from 2014, Financial Assistance (Economic Support) activities increased by 1% and Community Care increased by 4.28%.

Shown below are pie charts for revenue resources and expenditure streams.

Economic Support Consortium and Waiver TPA dollars were reclassified as State payments. This does not include Depreciation, and County indirect costs that are reportable to the State but not on Human Services Ledgers.

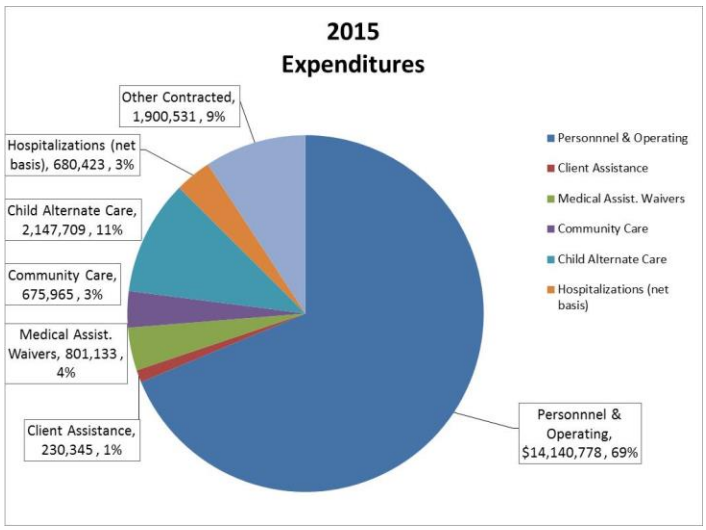


The above chart does not include Depreciation or County Indirect Costs. These costs are reportable to the state but are recorded on the county ledgers.
Depreciation amounted to $320,407 for 2015. County indirect charges for 2015 were $277,304.

The Hospitalizations are reported on a net basis (as revenue is received, that offsets expenditures)

Overall Expenditures Increased by $1,292,849 which was a 6.7% increase from 2014 actual. Personnel & Operating increased $626,467 from 2014

Child alternate care increased by $349,684 which was a 1.94% increase from 2014 actual.



FINANCIAL REPORTS

The Financial Reports that follow summarize Department resources and expenditures by source and type, target group, and service type. Data is presented in numeric and pie chart formats. Total resources for 2015, including County tax levy, were $21,109,865 plus carry forward of non lapsing funds from 2014 in the amount of $675,833. Providing a total revenue amount of $21,785,697. Total expenditures amounted to $20,576,833.

2015 Resources & Expenditures
(unaudited)

RESOURCES:	2014 ACTUAL	2015 ACTUAL	2015 BUDGET	2015 VARIANCE
State & Federal Funding	8,068,013	8,536,587	$ 8,841,920	305,333
Collections & Other	3,180,548	4,222,887	3,884,708	-338,179
County Funding for Ope	8,302,128	8,350,391	8,350,391	0
Total Resources	$ 19,550,689	$ 21,109,865	$ 21,077,019	-32,846

EXPENDITURES:	2014 ACTUAL	2015 ACTUAL	2015 BUDGET	2015 VARIANCE
Personnnel & Operating	$ 13,514,311	14,140,778	$ 14,771,513	630,735
Client Assistance	216,538	230,345	197,066	-33,279
Medical Assist. Waivers	557,822	801,133	1,191,029	389,896
Community Care	812,851	675,965	795,190	119,225
Child Alternate Care	1,798,025	2,147,709	1,805,531	-342,178
Hospitalizations (net ba	416,952	680,423	829,649	149,226
Other Contracted	1,967,535	1,900,531	1,920,644	20,113
Total Expenditures	$ 19,284,034	$ 20,576,883	$ 21,510,622	933,738

SUMMARY	2014 BALANCE	2015 BALANCE	2015 PERCENT of BUDGET
Surplus from operations	$ 266,655	$ 532,981	2.48%
2013 Carry Forward	$ 664,436	675,833	
Total Net Surplus	$ 931,091	$ 1,208,814	5.62%

2015 resulted in a net surplus of $1,208,814 or 5.62% of our total budget. We requested, and it was approved, that $992,259 of non lapsing funds be carried over into 2016. The remaining balance of $216,555 was returned to the general fund.

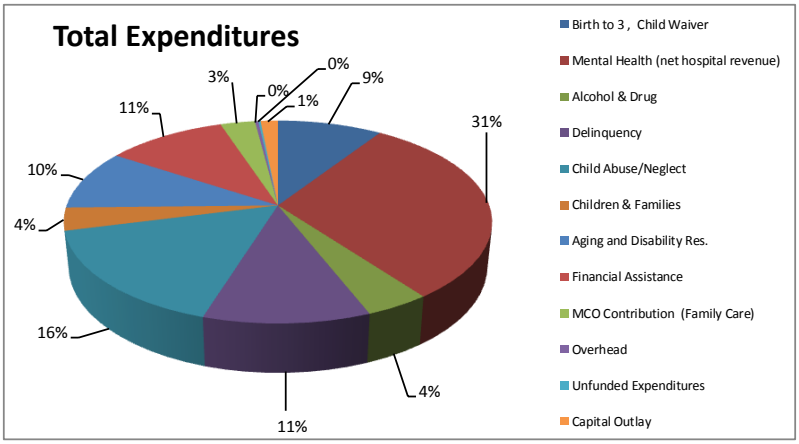
Depreciation	320,407
County Indirect Cost	277,394
	680,928

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers (County levy).

2015 Expeditures, Collections, and Costs

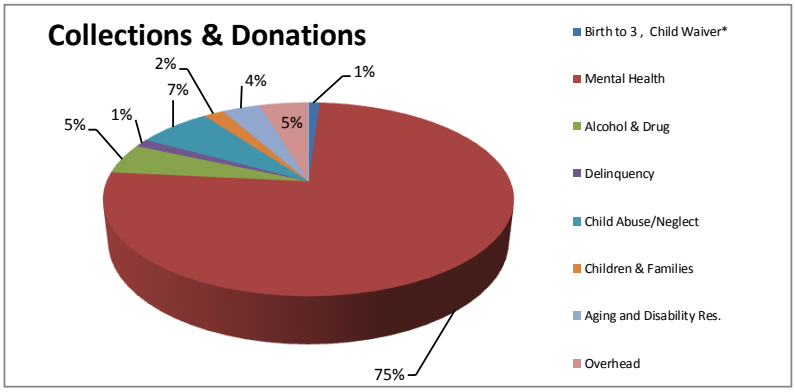
(does not include Depreciation & County Indirect Cost in pie chart)

Total Expenditures	
Birth to 3 , Child Waiver	1,885,660
Mental Health (net hospital revenue)	6,228,702
Alcohol & Drug	858,505
Delinquency	2,211,057
Child Abuse/Neglect	3,298,601
Children & Families	740,705
Aging and Disability Res.	1,960,097
Financial Assistance	2,168,285
MCO Contribution (*Family Care)*	625,097
Overhead	61,321
Unfunded Expenditures	41,146
Capital Outlay	311,561
TOTAL	20,390,736

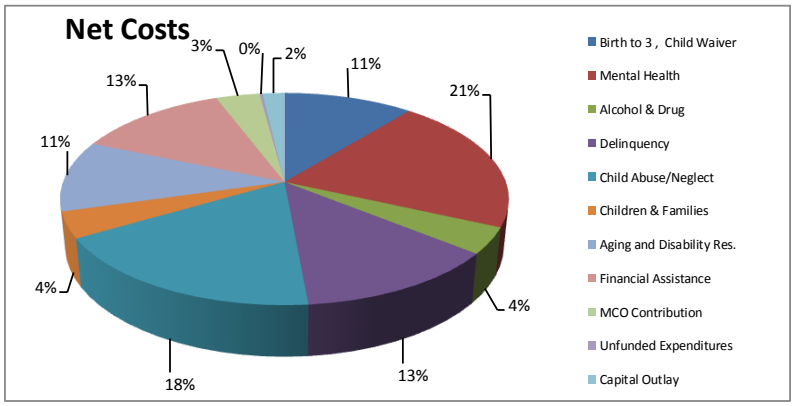


Collections & Donations	
Birth to 3 , Child Waiver*	38,048
Mental Health	2,704,787
Alcohol & Drug	181,491
Delinquency	49,124
Child Abuse/Neglect	247,266
Children & Families	67,937
Aging and Disability Res.	128,308
Overhead	165,962
TOTAL	3,582,923

Reclassified Consortium Economic Support and
Waiver TPA as State Payment
Hospital Collections are reported on net in expenditures



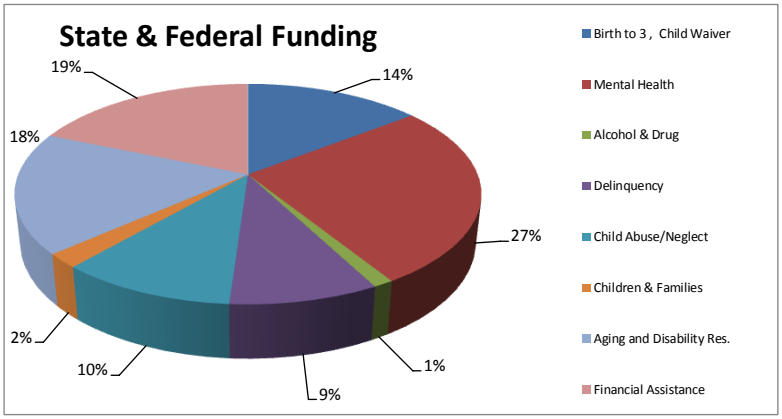
Net Costs	
Birth to 3 , Child Waiver	1,847,612
Mental Health	3,523,915
Alcohol & Drug	677,014
Delinquency	2,161,933
Child Abuse/Neglect	3,051,335
Children & Families	672,768
Aging and Disability Res.	1,831,789
Financial Assistance	2,168,285
MCO Contribution	625,097
Unfunded Expenditures	41,146
Capital Outlay	311,561
TOTAL	16,912,454



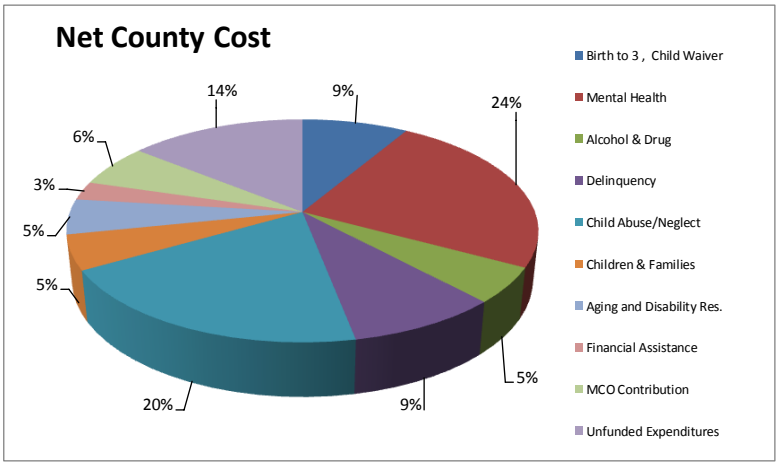
2015 Funding Streams and County Cost

State & Federal Funding	
Birth to 3 , Child Waiver	1,319,269
Mental Health	2,417,498
Alcohol & Drug	109,299
Delinquency	798,836
Child Abuse/Neglect	944,593
Children & Families	187,841
Aging and Disability Res.	1,620,135
Financial Assistance	1,697,573
TOTAL	9,095,044

Reclassified Consortium Economic Support and Waiver TPA as State Payment



Net County Cost	
Birth to 3 , Child Waiver	528,343
Mental Health	1,106,417
Alcohol & Drug	567,715
Delinquency	1,363,097
Child Abuse/Neglect	2,106,742
Children & Families	484,927
Aging and Disability Res.	211,654
Financial Assistance	470,712
MCO Contribution	625,097
Unfunded Expenditures	41,146
Capital Outlay	311,561
Tax Levy for Operations	7,817,410



NOTE Calculation of Levy	
Note Budget Tax Levy	8,350,391
Less: Net Positive Balance from operations	532,981
Tax Levy from Operations	**7,817,410**
Net Positive Balance from operations	532,981
Reserve from Balance sheet for Non-Lapsing	675,833
Balance Returned To General Fund	216,556
2014 Non Lapsing Request approved to be carried forward to 2015	**992,259**
Tax levy from Operations	7,817,410
Depreciation	320,407
County Indirect Cost	277,394
Total Tax Levy	**8,415,211**

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers.

The chart at right summarizes the amounts returned to the General Fund

Funds Returned to the General County Fund	
Year	**Amount**
2015	$216,555
2014	$255,259
2013	$0
2012	$0
2011	$884,018
2010	$100,378
TOTAL	**$1,456,210**

The chart below summarizes all donations and community grants the Department receives. Donations and grants received in 2015 is an increase of $4,807.03 from 2014.

DONATIONS AND GRANTS 2015		
DONATIONS	**Amount**	**Program**
Spacesaver	$500.00	Child Abuse Prevention
Watertown Unified School District	$260.00	Connections
Anthony Wedl	$100.00	Wraparound
Mad Enterprises	$167.00	CSP Consumer Council
Culver's	$240.00	CSP Consumer Council
Joseph Ganser	$100.00	Elderly Benefit Spec
Emma Hall	$25.00	Elderly Benefit Spec
St Peters Episcopal Church	$100.00	Elderly Benefit Spec
Total Donations	**$1,492.00**	
GRANTS	**Amount**	**Program**
Watertown Area United Way	$677.02	Wraparound
United Way of Jefferson & Walworth Counties	$1,000.00	Wraparound
United Way of Jefferson & Walworth Counties	$900.00	Incredible Years
Watertown Area United Way	$3,227.01	Incredible Years
Total Grants	**$5,804.03**	
Total Donations & Grants	**$7,296.03**	

Review of Staff Mileage and Vehicle Expenses

Over the last 7 years, we have endeavored to review all department systems for cost savings and efficiencies. The vehicle expense chart below is one example. In 2009 we paid $291,421 to staff for mileage. Over the last six years, we have added additional vehicles and have seen an average savings of $74,160 per year, even with additional vehicle expenses. The chart below summarizes this data with 2009 being the base year. The 2009 is the base year since department vehicles were only available on a very limited basis.

Staff Mileage and Vehicle Expenses							
	2009 Base Year	2010	2011	2012	2013	2014	2015
Total Staff Mileage Paid	269,112	180,174	155,922	160,553	153,189	129,802	127,481
Gas/Diesel	16,464	20,604	32,298	41,206	46,078	52,607	33,356
Non Capital & Capital Auto	8	9,001	13,007	9,509	19,018	2,009	16,178
Sale Squad Vehicles	0	0	-1,495	-1,988	-400	-2,003	0
Vehicle Parts & Repairs	5,837	11,413	16,910	17,954	24,033	18,334	18,817
Total Expense	291,421	221,192	216,642	227,234	241,918	200,749	195,832
Savings Compared to Base Year		$ 70,229	$ 74,779	$ 64,187	$ 49,503	$ 90,672	$ 95,589
Average Saving per last 6 years							$ 74,160

Review of 2015 Goals:

<u>The Key Outcome Indicator</u> was 100% compliance with reporting requirements as denoted on work chart.

100% Compliance with reporting requirements was met.

1. **Accurately complete all county, state and federal reports and billing:**
   State & Federal budget requires numerous budgets and reports for the programs that provide by the Department. We also must be compliant with Medicaid and Medicare requirements.
   GOAL was 100% compliance with reporting requirements as denoted on work chart for the fiscal department for HSD. We were compliant with timely reporting to the state. All billing claims were submitted for the year by February.
2. **Implementation of ECHO System for Fiscal/Support Area:** Manage the fiscal/support functions within ECHO system to ensure payment of bills/scheduling.
   GOAL: Was to have timely/accurate bills to be generated from ECHO per implementation schedule.
   GOAL: Was to be able to schedule appointments for clients and to have case managers understand the ECHO Scheduling Requirements.
   Set up of Echo and training for staff did occur in 2015. Due to Echo system implementation being delayed, this goal was not able to be finalized.
3. **To complete Projects in 2015.**
   GOAL: Efficiency is important for the administrative area. With limited resources within the department and the installation of ECHO, evaluation of workflows will occur. During the installation of ECHO we evaluated ways to streamline current jobs. We will identify projects to insure that we are measuring productivity both prior and after changes.

   Due to Echo system implementation being delayed, this goal was unable to be finalized. The work flow was analyzed. Training of staff on these activities occurred in 2015. Many forms have been built that have triggers and review dates to insure compliance with required deadlines.

   NIATx Project completed in 2015:

   Problems with Hotel room reservations for people attending trainings.
   Hotels want to see a credit card when people going to trainings check in. The only credit card the department had for making purchases could not be given to the worker when they were going on a trip. Sometimes the hotel would accept a check; however this had to be done well in advance so that the check would be received prior to the training. This was not always an option.
   The adopted plan was that a credit card was issued for each division. Each worker can then sign out the card and return the card with all necessary receipts.

2016 GOALS

<u>The Key outcome indicator</u>

- **Accurately complete all county, state and federal reports and billing:**

State & Federal budget requires numerous budgets and reports for the programs that provide by the Department. We must be compliant with all Medicaid and Medicare requirements.

GOAL is 100% compliance with reporting requirements as denoted on work chart for the fiscal department for HSD.

1. **Complete 2 continuous quality improvement projects using the NIATx model and write them up.**
2. **Facilitate complete implementation of electronic health record.**
3. **Review work duties for each area and re-distribute duties as needed.**
4. **Continue to revise, review, and improve billing methodology.**
5. **Review, revise, and improve compliance procedures; including HIPAA, Client Rights, and Confidentiality.**

MAINTENANCE

~Increasing productivity and profits through Improved Operations~

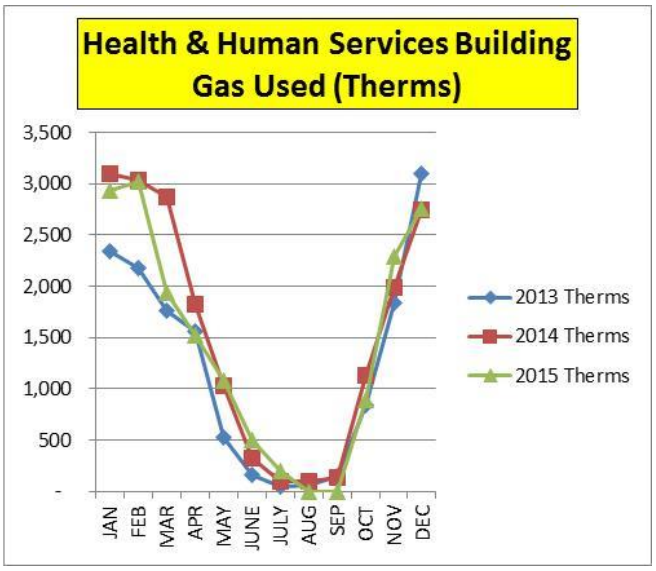
Review of Utility Costs
Health/Human, Workforce/UW Extension, Lueder House and Hillside Buildings

We are in our 7th year of tracking utilities for all of the Human Services buildings. In 2015, we upgraded our Tridium HVAC program which will allow for future energy savings. As we determine the areas of need for energy efficiencies, we look to lower the square footage operation costs.

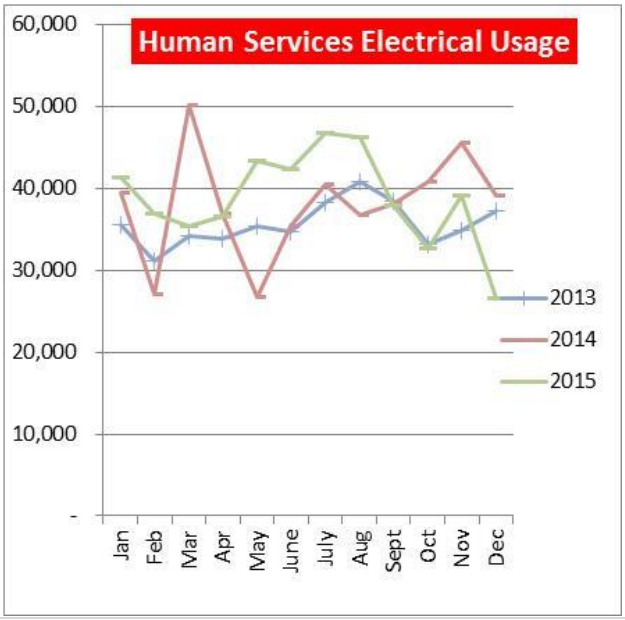
UTILITY USAGE FOR HEALTH & HUMAN SERVICES BUILDINGS

2015 utility usage shows a reduction in gas usage due to a mild winter, however the electric use is on the same upward trend.

Health & Human Service Bldg. Gas Used (Therms)			
Month	2013 Therms	2014 Therms	2015 Therms
JAN	2,338	3,102	2,935
FEB	2,178	3,039	3,017
MAR	1,766	2,872	1,933
APR	1,558	1,830	1,518
MAY	531	1,024	1,080
JUNE	165	318	499
JULY	44	92	195
AUG	58	103	-
SEP	146	133	-
OCT	846	1,136	888
NOV	1,840	1,985	2,297
DEC	3,102	2,741	2,757
TOTALS	**14,572**	**18,375**	**17,119**



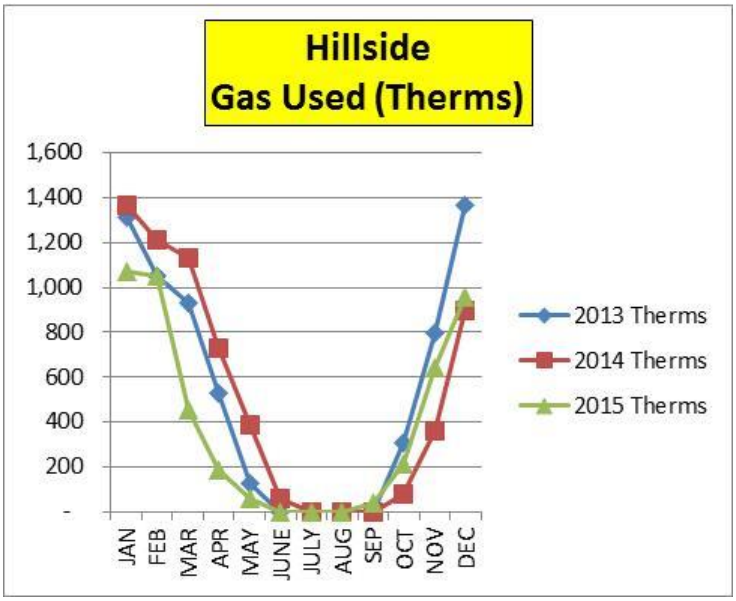
Electric Usage - KWH - Human Services			
	2013	2014	2015
Jan	35,520	39,440	41,280
Feb	31,120	27,120	36,960
Mar	34,160	50,240	35,360
Apr	33,920	36,880	36,560
May	35,440	26,720	43,360
June	34,800	35,440	42,400
July	38,320	40,480	46,800
Aug	40,880	36,720	46,240
Sept	38,480	38,080	37,920
Oct	33,200	40,880	32,640
Nov	34,880	45,680	39,120
Dec	37,280	39,120	26,640
TOTALS	**430,013**	**458,814**	**467,295**



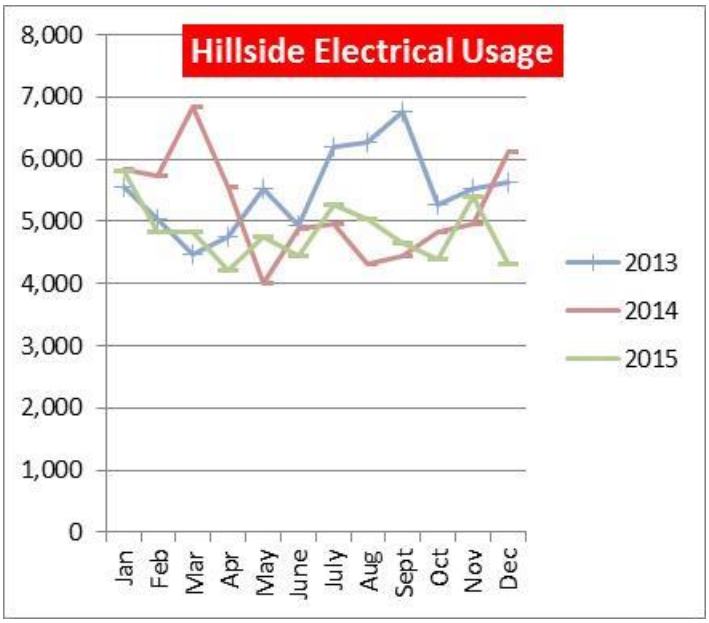
UTILITY USAGE FOR
HILLSIDE BUILDING

2015 utility usage shows a reduction in gas and electric usage due to a mild winter and the controls that were installed to eliminate continuous run times on our boiler pumps.

Hillside Gas Used (Therms)			
Month	2013 Therms	2014 Therms	2015 Therms
JAN	1,315	1,368	1,073
FEB	1,048	1,211	1,050
MAR	932	1,131	452
APR	531	730	186
MAY	123	386	58
JUNE	-	61	-
JULY	-	-	-
AUG	-	-	-
SEP	-	-	40
OCT	305	76	210
NOV	799	362	645
DEC	1,368	894	955
TOTALS	**6,421**	**6,219**	**4,669**



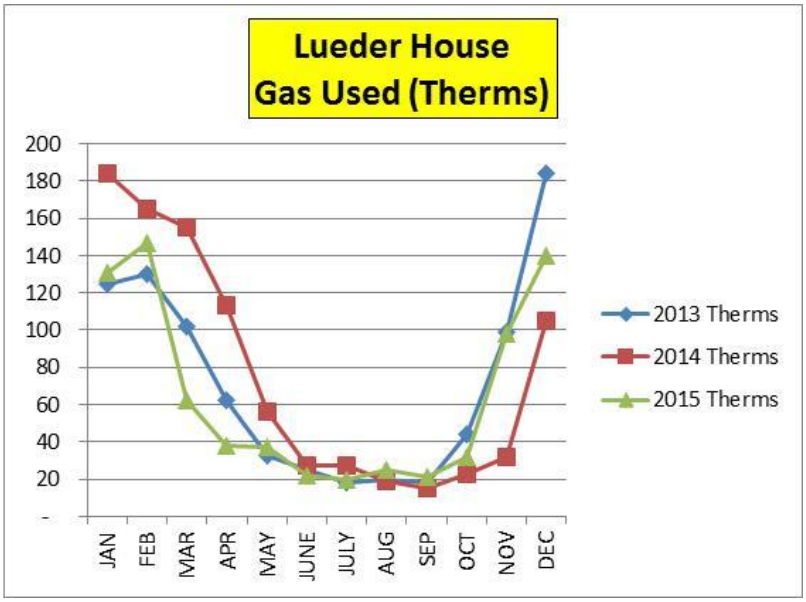
Electric Usage KW Hours - Hillside			
	2013	2014	2015
Jan	5,560	5,840	5,800
Feb	5,040	5,720	4,840
Mar	4,480	6,840	4,840
Apr	4,760	5,560	4,200
May	5,520	4,000	4,760
June	4,920	4,880	4,440
July	6,200	4,960	5,280
Aug	6,280	4,320	5,040
Sept	6,760	4,440	4,640
Oct	5,280	4,840	4,400
Nov	5,520	4,960	5,400
Dec	5,640	6,120	4,320
TOTALS	**67,973**	**64,494**	**59,975**



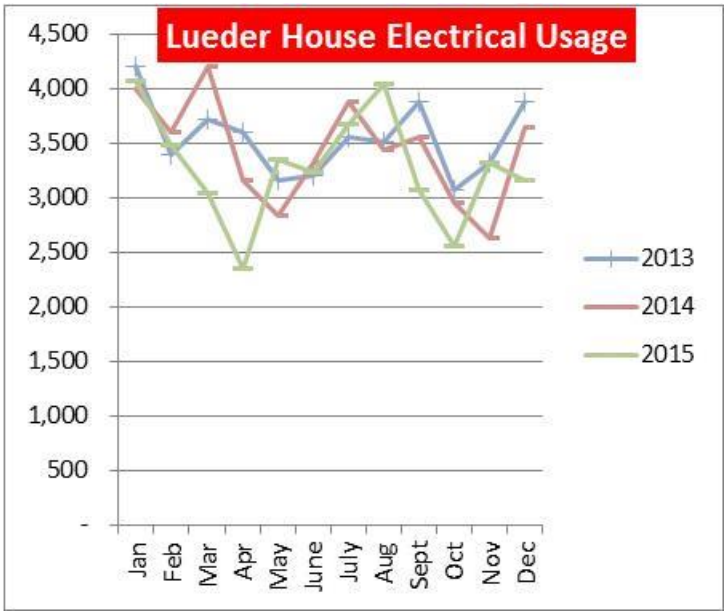
UTILITY USAGE FOR
LUEDER HOUSE

2015 utility usage shows a reduction in gas and electric usage due to a mild winter.

Lueder House Gas Used (Therms)			
Month	2013 Therms	2014 Therms	2015 Therms
JAN	125	184	131
FEB	130	165	147
MAR	102	155	62
APR	62	113	38
MAY	33	56	37
JUNE	25	27	22
JULY	18	27	20
AUG	20	19	25
SEP	18	15	21
OCT	44	23	32
NOV	99	32	98
DEC	184	105	140
TOTALS	**860**	**921**	**773**



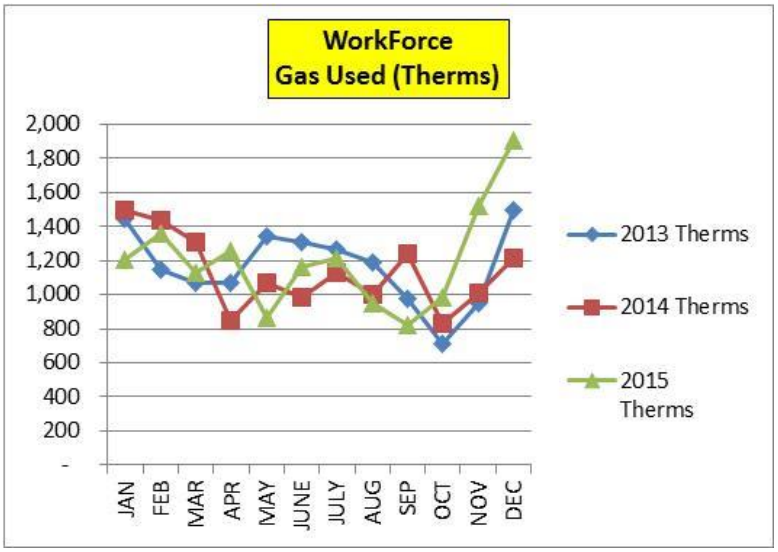
Electric Usage - Lueder House			
	2013	2014	2015
Jan	4,200	4,000	4,080
Feb	3,400	3,600	3,480
Mar	3,720	4,200	3,040
Apr	3,600	3,160	2,360
May	3,160	2,840	3,360
June	3,200	3,320	3,240
July	3,560	3,880	3,680
Aug	3,520	3,440	4,040
Sept	3,880	3,560	3,080
Oct	3,080	2,960	2,560
Nov	3,320	2,640	3,320
Dec	3,880	3,640	3,160
TOTALS	**44,533**	**43,254**	**41,415**



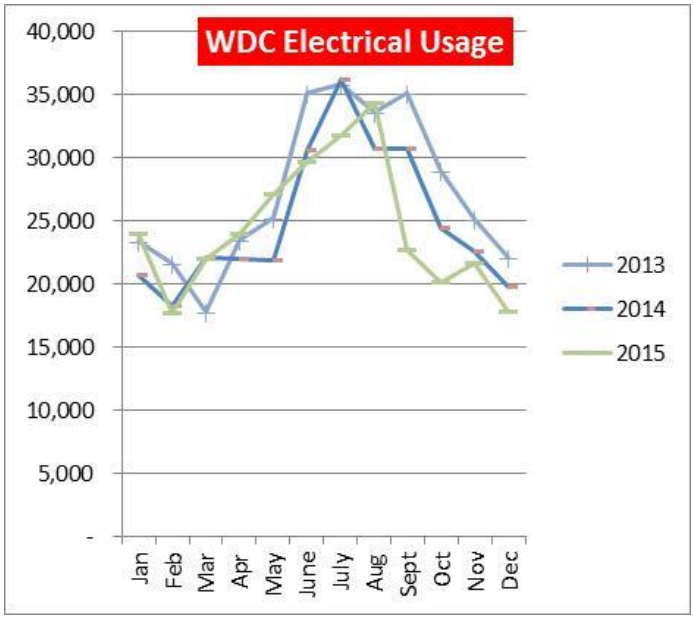
UTILITY USAGE FOR
WORKFORCE DEVELOPMENT CENTER

2015 utility usage shows an increase in gas usage. The electric usage has decreased due to the LED parking lot lights.

Work Force Gas Used (Therms)			
Month	2013 Therms	2014 Therms	2015 Therms
JAN	1,442	1,493	1,209
FEB	1,145	1,437	1,355
MAR	1,073	1,311	1,127
APR	1,071	843	1,258
MAY	1,345	1,065	863
JUNE	1,310	982	1,159
JULY	1,263	1,131	1,216
AUG	1,191	1,003	953
SEP	972	1,241	818
OCT	712	834	986
NOV	952	1,008	1,523
DEC	1,493	1,215	1,903
TOTALS	**13,969**	**13,563**	**14,370**



Electric Usage - KWHours - WDC			
	2013	2014	2015
Jan	23,360	20,720	23,920
Feb	21,680	18,240	17,680
Mar	17,760	22,080	21,920
Apr	23,520	21,920	23,920
May	25,280	21,840	27,120
June	35,120	30,560	29,680
July	35,760	36,160	31,760
Aug	33,600	30,720	34,320
Sept	35,120	30,720	22,720
Oct	28,960	24,400	20,160
Nov	25,120	22,560	21,600
Dec	22,080	19,760	17,760
TOTALS	**329,373**	**301,694**	**294,575**



CAPITAL IMPROVEMENTS SUMMARY OF BUILDINGS, EQUIPMENT, AND PHYSICAL PLANT

Hillside House 1938
Head Start renovation 1987
Electrical upgrade early 1990's
Replaced boiler 2010
Added entry door access control 2013
Replaced roof, added insulation 2013
Replaced office lighting to T8 2013
Replaced 7 A/C units with air handlers 2014
Replaced sidewalks 2014
Replaced two entry doors 2014
Replaced sewer line in floor 2014
Upgrade to Tridium System 2014
Painting 2014
Remodeled bathroom into two offices 2015

Health/Human Building 1980 portion
Remodeled basement 1989
Replaced roof membrane/gutters 2003
Replaced rooftop HVAC unit 2007
Replaced four rooftop unit heaters 2009
Remodel TPR room 2010
Added door access control 2013
Replaced flooring 2013
Remodel Viewing room 2013
Replaced office lighting with T8 2013
Remodeled three work regions 2014
Added BR Glass at main reception 2014
Replaced two entry doors 2014
Upgrade to Tridium System 2014
Replaced sidewalks 2014
Added LED lighting 2014
Replaced vestibule unit heater 2014

Health/Human Building 1995 portion
Installed Back-up generator 2008
Replaced flooring in Health lab and exam rooms 2008
Remodeled Intake area 2010
Seal coat re-stripe parking lot 2010
Added access control 2013
Replaced A/C coil and compressor 2013
Replaced three boilers with some DD Control 2013
Remodeled Health Department conf room 2013
Replaced damaged heating coil 2014
Added BR Glass at ADRC & Health Reception 2014
Upgrade to Tridium System 2014
Added LED lighting 2014
Added BR Glass in Health Dept 2015
Updated Tridium Software Programming 2015

WDC/UWX Building 1999
Installed backup generator 2005
Remodeled call center 2013
Repaired A/C coil 2014
Replaced flooring 2014
Added LED lighting 2014

Lueder Haus/CSP 1996
Remodeled/Added CSP offices 2004 - 2010
Replaced A/C condensing unit 2012
Added LED outside lighting 2013
Modified deck 2013
Painting 2013
Replaced all flooring 2014
Completed backup generator 2015

Review of 2015 Goals: **All goals were met.**

1. **Key Outcome Indicator: 100% of capital projects completed on time and within budget.**

2. Request proposals to install a whole house back-up generator for Lueder Haus.

3. Request proposals to install BR Glass for the reception area located in the lower level of the Health Department.

4. Continue to build onto the Tridium Automation system for all of the HVAC mechanicals.

5. Complete Hillside office remodeling project.

6. Continue to maintain all buildings and fleet vehicles in optimum condition.

2016 GOALS for MAINTENANCE

1. **Key Outcome Indicator: 100% of capital projects completed on time and within budget.**

1. Maintain mechanical equipment in all buildings for energy efficiencies
2. Continue installation of Tridium system and prepare for future mechanical upgrades
3. Develop a solar electric feasibility study for Workforce Development Center
4. Build "Facility Dude" to streamline routine maintenance and analyze building costs
5. Lower utility costs per square footage

SUPPORT STAFF

~Assisting staff and customers to ensure a seamless delivery of services~

The Support Staff is a vital team within the department working diligently behind the scenes. We help external customers by making appointments and providing information. It is imperative that our team is knowledgeable about all county resources so that we can direct customers to the proper agencies, such as local food pantries or PADA. We also process requests for the release of medical records which requires staff to understand the many statutes covered under HIPAA, Mental Health, AODA, and Child Welfare.

We assist internal customers by maintaining charts and client paperwork, typing and processing reports, making appointments, and helping with special projects. Having excellent communication skills are critical for our staff due to the constant changes throughout any given day. All staff are also crossed trained and able to backup each other to ensure a seamless delivery of services to both internal and external customers.

Review of 2015 Goals:

1. **Key Outcome Indicator: Maintain excellent customer service as indicated by an internal customer satisfaction survey.** A satisfaction survey was completed. We addressed the few concerns, but overall our team received positive results.
2. **Support all agency staff and maintain all records according to mandate 46 via internal customer survey project.** This was accomplished.
3. **Ensure that all support staff can locate important documents while working at the front desk via a project.** This is in progress.
4. **Become proficient in the ECHO, electronic health record system.** We had dozens of trainings and feel confident that we will be proficient in ECHO when it goes live.

5. **Become proficient in the DrFirst program and have the ability to assist the Dr and Nurse Practitioner.** We had several trainings and continue to work on this.

6. **Purge old microfilm.** We have purged old microfilm and continue to purge as the statute allows.

7. **Complete the re-sorting of charts.** This was accomplished.

8. **Continue process for auditing chart files to monitor that filing is complete and filed correctly.** This was accomplished.

2016 GOALS:

Beginning in 2016, Support Staff will work directly within their respective team, so the goals will be incorporated into each of those areas.

AGING & DISABILITY RESOURCE DIVISION

"An inclusive community where older adults and people with disabilities are respected, healthy and productive."

Our purpose is to advocate for and help people achieve their goals by providing them with comprehensive information, assistance and opportunities to engage in the public policy process so they can make informed decisions and remain in charge of their lives.

The Aging & Disability Resources Division of Jefferson County Human Services encompasses many programs and funding streams that provide services and supports to the elderly, adults with disabilities, children with disabilities as they transition into adulthood, and persons with Alzheimer's Disease or another dementia and their caregivers. Services and supports are intended to help people live with a high degree of independence in their own homes and communities for as long as they desire. We adhere to the principals of motivational interviewing to help people achieve their best possible outcomes.

Our services include:

- Adult Protective Services
- Advocacy
- Benefit Specialist
- Caregiver Support
- Dementia Care Specialist
- Eligibility Determinations for Family Care, Partnership or IRIS
- Farmer's Market Vouchers
- Health & Wellness Programs
- Housekeeping Assistance
- Home Delivered Meals
- Information & Assistance
- Investigate Abuse/Neglect Referrals
- Memory Screening
- Options Counseling
- Outreach
- Preadmission Consultations
- Senior Dining
- Transportation
- Volunteer Opportunities

Oversight

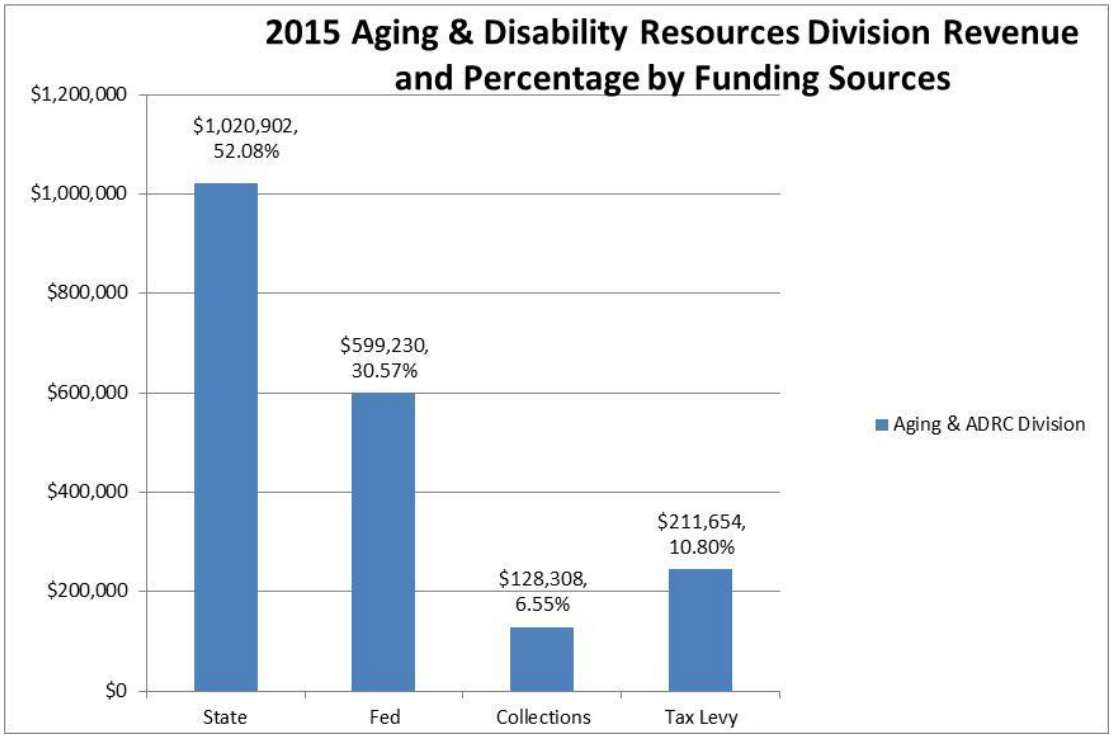
Many of the above services are mandated via federal legislation called the Older American's Act (OAA) which promotes advocacy as a core service. The OAA provides the framework under which the division's two oversight committee's exist and operate.

1: Aging & Disability Resource Center Advisory Committee

This committee is actively involved in oversight and planning efforts on behalf of the division's constituents and is responsible for advising the Human Services Board about programs, policies and unmet community needs.

2: Nutrition Project Council

This council is responsible for advising the Nutrition Program Director on all matters relating to the delivery of nutrition and nutrition supportive services within the program area, including making recommendations regarding days and hours of meal site operations and site locations, setting the annual "suggested donation," and making recommendations regarding meal site furnishings with regard to persons with disabilities.



Depreciation	$32,049
County Indirect Cost	$36,577

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers (County levy).

AGING & DISABILITY RESOURCE DIVISION

Aging & Disability Resource Center

Adult Protective Services

Alzheimer's Family Caregiver Support Program

Dementia Care Specialist

Disability Benefit Specialist

Elder Benefit Specialist

National Family Caregiver Support Program

Senior Dining Program

Transportation Program

AGING AND DISABILITY RESOURCE CENTER

"Providing comprehensive, up-to-date information, assistance and decisional support to help older adults and persons with disabilities achieve their desired outcomes."

Program Description: *Answers and Solutions Start Here*

Aging and Disability Resource Centers (ADRC's) offer the general public a single entry point of access for information and assistance on issues affecting older people and people with disabilities, regardless of their income. Individuals, family members, friends or professionals working with issues related to aging, physical or developmental/intellectual disabilities can receive information specifically tailored to each person's situation. The ADRC brings to the community a blend of public and private supports and community resources to empower their customers with the ability to make informed choices and decisions regarding options available as well as take into account the consumers' private resources. In 2015, the ADRC had 6,491 contacts with 1,843 unduplicated individuals to provide information, assistance and referrals. Below is a snapshot of information on the consumers we served in 2015.

Contact Types, Consumer Age and Disability Category – 2015 Data

	Jan - March	April - June	July - Sept	Oct - Dec	Total
Incoming Phone Call	632	689	719	590	2630
Outgoing Phone Call	316	308	294	354	1272
Office Visit Scheduled	69	63	47	46	225
Walk-in	58	222	56	68	404
Home Visit	147	149	197	138	631
Email	99	132	186	218	635
Fax/Written	185	132	205	40	562
Consumer Age 18 - 59	446	478	432	406	1762
Consumer Age 60 - 150	894	1051	1085	1082	4112
Intellectual Disability	164	228	201	136	729
Elderly	855	942	1053	997	3847
Mental Health	129	176	136	151	592
Physical Disability	386	329	345	379	1439
Substance Use/AODA	23	15	17	9	64
Unknown	166	210	143	98	617
Total # of Unduplicated Calls	1506	1695	1703	1586	6491
Total # Unduplicated Callers	508	691	545	475	1843

Review of 2015 Goals

1. **Key Outcome Indicator: 100% of ADRC customer surveys indicate that they would refer the ADRC to someone else.** This goal was not met. Our survey response in 2015 for recommending the ADRC to someone else was 97.87%.

2. **The ADRC and Care Transitions Workgroup will work toward developing a plan to reduce readmissions to the hospital which occur within 30 days of discharge.** The goal was met. Community partners worked with MetaStar, a quality improvement organization, to complete a root cause analysis of the most prevalent readmission diagnosis. We found that the county's readmission rate under this diagnosis was 17.24% vs. the state average of 16%.

    - As a result of the findings, the Safe Swallowing Train-the-Trainer Program was created.
    - At the 2 trainings provided, there were 24 individuals trained from 11 community facilities.

3. **The ADRC administers the Senior Farmers' Market Nutrition Program (SFMNP) for Jefferson County.** In 2015, our goal was to increase the number of seniors redeeming the vouchers. This goal was met; the redemption rate was 81% and the previous year was 76%.

4. **The ADRC worked on a two-part Aiming for Excellence Project to increase staff knowledge about cultural diversity and to increase awareness of the ADRC by translating marketing materials for use by non-English speaking Hispanic customers.** These goals were met.

    - Staff received training to increase their knowledge of communication with non-English speaking consumers.
    - A resource brochure called the Youth Transition Roadmap was translated into Spanish and 20 copies were distributed to each school district.
    - The ADRC poster was translated into Spanish and distributed throughout the county in 46 locations to create awareness of the ADRC services.

5. **The ADRC will translate agency created brochures and handout materials, such as the Benefit Guide and Senior Farmer's Market Voucher Program Guide.** This goal was not met due to insufficient funding.

6. **Continue to promote the ADRC and raise awareness of programs and issues relating to aging and maintaining independence for people with a disability.** This goal was met; an increase of 14.5 % of unduplicated callers contacted the ADRC.
    - The ADRC participated in 12 community outreach events with an estimated count of 657 individuals.
    - The ADRC conducted 13 community presentations with an estimate of 360 participants; this is a 60% increase of individuals from the previous year.

2016 Contract

The 2015-2017 Governor's Budget contained provisions that would have significantly changed how ADRC's operate. While the provisions did not pass, the legislature did direct the Department of Health Services (DHS) to conduct several studies and report back to the legislature on their findings.

The first study requires DHS to evaluate the functional screen and options counseling functions for reliability and consistencies among ADRC's and provide a report back to the legislature 1/1/17. The Long Term Care

Functional Screen is used to determine functional eligibility for Family Care, Partnership and IRIS, Wisconsin's publicly funded long term care programs. The organization that conducts the screen must be independent of these three programs to ensure that when administered it is free of conflict of interest. In 2015 the ADRC completed 212 long-term care functional screens on 190 consumers.

The second study requires DHS to assess which responsibilities of ADRC governing boards are duplicative with current DHS procedures and to propose changes to the statutory requirements of these boards to remove duplication no later than 7/1/16.

The third study requires DHS to study the integration of income maintenance consortia and ADRC's and present a report no later than 4/1/16 with recommendations regarding potential efficiencies that may be gained and whether such a merger would be appropriate. It is unclear how this requirement evolved but both ADRC's and Income Maintenance Consortia are opposed to a merger. ADRC's are not call centers, whereas the consortia are. ADRC's do not determine eligibility for publicly funded programs, the consortia does. ADRC's and the consortia are very different in terms of design, function and scope of services.

As a result of the 2015-2017 state budget, the 2016 Department of Health Services contract with the ADRC now requires us to complete a **Business Plan** and an **Evaluation & Compliance Plan**

Business Plan: The objective of this plan is to help ADRC's identify their costs on a per contact/per customer basis, reach new customers and increase the number of new ADRC contacts. It is due 11/1/2016.

Evaluation & Compliance Plan: The ADRC meets the majority of requirements in the compliance plan, which covers location, facility space, accessibility, signage, accessible parking, private rest rooms, private reception areas, hours of operation, telephone and an approved management information system. In addition there are new requirements for using the ADRC logo on the blue and white color scheme.

The majority of requirements are met. In 2016 the compliance issues that need to be addressed include:

- Ensuring that all ADRC Signage contains the blue logo on the white background;
- The ADRC logo and phone number are on the main page of the county website;
- The preferred hours of operation by the community have been assessed;
- The telephone system has the capacity to track and report hold times and abandoned calls.

Some of the above requirements will be difficult to meet due to local policies and cost. The Department of Health Services will review each plan and suggest a recommended course of action based on statewide results.

2016 Goals

1. **Key Outcome Indicator: 100% compliance with the State Contract.**

   A. **Compliance Plan:**
   The compliance requirements in the State Contract under Section II, Scope of Services must be evaluated by the ADRC and submitted for approval by March 1, 2016. For areas of non- compliance, the ADRC shall work with its Department of Health Services, DHS, Regional Quality Specialist, RQS, to develop a timeline, and identify if resources are available from the current ADRC allocation to come into compliance. An ADRC's timeline and plan to come into compliance must be completed by May 1, 2016, to avoid corrective action.

- The checklist for the Evaluation and Compliance Plan requirement for the 2016 ADRC Scope of Services was submitted to the DHS Assigned Regional Quality Specialist (RQS) for review by the March 1, 2016 deadline.
- By May 1, 2016, all contract requirements identified as non-compliant will be corrected unless funding is not available. In that case, we will work on a strategic plan to come into compliance with the RQS. The following items have been identified and are being reviewed to meet compliance requirements:
    - All ADRC locations will have clearly visible signage showing the Department's ADRC logo in the Department's blue and while color scheme.
    - By May 1st, the ADRC will be assessed for the most convenient days and times for customers to visit the ADRC.
    - The ADRC logo and phone number will be located on the main page of the county website.
    - The telephone system will have the capacity to track and report hold times and abandoned calls.

B. Business Plan

By November 1, 2016, the ADRC shall submit a business plan to DHS that provides options to improve the ADRC performance in reaching new customers and increasing the number of new contacts. A template to gather requested data has been created by DHS.

a. The business plan will include the number of customers, the number of contacts, the number of contacts per customer for known customers, the number of contacts not associated with a customer and costs for providing each of the following services:
    - Information and Assistance / Options Counseling
    - Enrollment & Disenrollment Counseling
    - Services to Youth in Transition
    - Dementia – related services
    - Nursing Home Relocations
    - Other

b. The ADRC will calculate costs per contact and cost per customer.

c. The ADRC will assess how well it meets its current customer's expectation in the following areas:
    - Ease of contacting or locating the ADRC
    - Hours of Operation
    - Phone answering protocols
    - Building and office space
    - Services offered

2. <u>Key Outcome Indicator -</u> 100% of home visit requests shall be done within 7 days unless the customer requests otherwise.

To provide quality services, the ADRC incorporates continuous quality Improvement in its operation. Monthly quality assurance reviews are conducted to ensure that home visits are scheduled within 7 days of the consumer's initial request.

- Maintain 100% contract compliance

- Examine, discuss and review contract and policies with all ADRC staff

- Monthly review of Consumer Satisfaction Surveys.

- Staff will participate in annual compliance and HIPAA training.

3. The ADRC administers the *Senior Farmers' Market Nutrition Program (SFMNP) for Jefferson County. In 2015, the redemption rate for the vouchers was 81% and the previous year was 76%. Our goal will be to increase the number of seniors redeeming the vouchers to 86% or higher.*

4. The ADRC will work on two **Aiming for Excellence Projects.**

Disability Benefit Specialist

The Disability Benefit Specialist Program offers services to Jefferson County residents with disabling conditions ages 18-59 by Disability Benefit Specialists. Services are provided to address the following issues: Income Support, Health and Long-Term Care, Employment, Food, Housing and Utilities.

From January through December 2015, the Disability Benefit Specialist assisted 235 individuals with specific case services and 117 individuals requesting a brief telephone or mail contact service. Through applications and appeals, the value of gained benefits for Jefferson County was $1,533,524 in Federal Funds, $220,622 in State Funds and $17,512 in Other Funds for a total of $1,771,658 impacting the local economy.
Review of 2015 Goals: Goals were met.

In 2015, the Disability Benefit Program increased outreach efforts by working on a federally funded Medicare Improvement for Patients and Providers Act (MIPPA) project that was taking place in Wisconsin. This was an effort to increase knowledge and enrollment in available Medicare and Medicaid programs to eligible residents. The Disability Benefit Specialists helped to organize a group of agencies across county lines to cooperatively offer a community education event. By the end of 2015, the Disability Benefit Specialist Program realized an increase in Medicare/Medicaid cases from 104 in 2014 to 123 in 2015.

2016 Goals:
The Disability Benefit Specialist program will increase its efforts to educate consumers about health insurance by targeting the uninsured population. This effort will include outreach efforts, developing educational materials and providing case services.

Activities to achieve this goal will be:

- Develop a promotional flyer targeting uninsured consumers with disabilities
- Distribute the flyers in the community
- Meet with consumers to discuss options for obtaining health insurance
- Complete applications for health insurance with consumers as needed

The DBS will use program statistics to measure success of the outreach project based on increased numbers of service and informational cases. We have targeted a 5% increase in the number of consumers who receive a health insurance benefit.

AGING PROGRAMS

~Providing community based services to support older adults in their own homes~

Alzheimer's Family Caregiver Support Program

The Alzheimer's Family and Caregiver Support Program (AFCSP) was created by the Wisconsin legislature in 1985 in response to the stress and service needs of families caring at home for someone with irreversible dementia. To be eligible, a person must have a diagnosis of Alzheimer's disease or a related disorder, and be financially eligible. A maximum benefit of $4,000 per family, per calendar year is available. The county's total allocation serves approximately 5 families.

Review of 2015 Goals:

1. 100% of families being served will be offered the ***Memory Care Connections Program*** through the Dementia Care Specialist. *This goal has been accomplished; however families have been reluctant to sign on to this ongoing program/commitment.*

2016 GOALS: All goals related to households supporting someone with dementia are found in the Dementia Care Specialist section.

Dementia Care Specialist (DCS)

In 2010, the Alzheimer's Association reported 1,576 persons in Jefferson County had Alzheimer's disease or another dementia and in 2030 they project that number to increase to 2,438, which is a 55% increase. Also in 2010, 453 persons aged 65+ that had been diagnosed with Alzheimer's disease were living alone in Jefferson County. It is estimated that 75% of those diagnosed live alone.

Jefferson County has employed a Dementia Care Specialist since 1/2/13. Funding for the position comes from state GPR dollars and federal Medicaid matching funds via the ADRC contract between the county and Department of Health Services.

Review of 2015 Goals:

1. **Key Outcome Indicator: By December 31, 2015, information about DCS services and available supports will be provided to all county departments.** *This goal has been met by providing articles on dementia via the county's employee E-newsletter*
2. **"Dementia Friends" will be trained to reach out to businesses wanting to become Dementia Friendly.** *This goal was met through a training provided to the Dementia Community Network. Fifteen individuals were trained.*
3. **Organize one local conference in 2015 to raise awareness about dementia in the local community.** This goal was met and the first Dodge/Jefferson Regional Dementia Conference was held in Johnson Creek in November. Ninety people attended and 50% of them were caregivers. 100% of the evaluations indicated that they strongly agreed (79%) or agreed (21%) that they were satisfied with the conference.
4. **Provide one in-service to the staff at Fort Atkinson Hospital in conjunction with the Alzheimer's Association.** This goal was met in June of 2015. The presentation was on dementia in general. It described how the Human Services Department responds to people with dementia in the ER and what the Agency can do and what we cannot do from a legal standpoint in crisis situations. The session was videotaped and has since become a required staff in-service.

5. Present at the May 2015 Annual Alzheimer's Conference on work being done by the Person Centered Dementia Care Mentors Alliance in Jefferson County. This goal was met. The Dementia Care Specialist spoke at preconference intensive and other alliance members joined her for a panel presentation on the first day of the conference.

2016 Goals:

1. **Key Outcome Indicator: 80% of Jefferson County's board members and employees will be trained on the principles of becoming a Dementia Friendly Business model by 3/31/16.**
2. **By 1/31/2016, the Person Centered Dementia Care Alliance will begin piloting a person centered care planning tool for caregivers to utilize when their loved one transitions from one setting to another. The intent is to minimize trauma associated with transitions.**
3. **By 12/31/2016, 100% of the libraries in Jefferson County will be provided with caregiving resources pertinent to dementia.**

Senior Dining Program

The Elderly Nutrition Program, enacted by Congress in 1972, provides grants to support nutrition services to older people throughout the country to improve the dietary intake of participants and to offer them opportunities to form new friendships and to create informal support networks. The legislative intent is to make community-based services available to older adults who may be at risk of losing their independence.

The purpose of the elderly nutrition program is:

- To reduce hunger and food insecurity;
- To promote socialization of older individuals; and
- To promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services designed to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

REVIEW OF 2015 GOALS:

1. **Key Outcome Indicator: 100% of seniors completing satisfaction surveys report that they are not experiencing hunger or food insecurity.** *This goal was not met. In 2016 Nutrition Program staff have developed new goals that focus on achieving this outcome.*
2. **100% of meals delivered will be at the proper temperatures.** *This goal was not met 100% of the time. A new policy has been put in place.*
3. **100% of meals served and delivered will be recorded in Social Assistance Management Software within 30 days of the serving month.** *This goal was met all twelve months of the year.*
4. **The catering contract will contain the business' Continuity of Operations plan.** *This goal was met. The program was rebid in 2015 and the requirement was made part of the bid package.*
5. **100% of site manager absences will be covered.** *This goal was met despite considerable staffing issues. Nutrition program staff should be commended for ensuring that no-one went without a meal.*

2016 Goals:

1. **Key Outcome Indicator 1: 100% of seniors completing satisfaction surveys report that they are not experiencing hunger or food insecurity.**
2. **Key Outcome Indicator 2: 95% of qualifying home delivered meal requests are served.**

3. In order to increase awareness of local food resources, the program's nutritionist will complete 6 on-site trainings by 12/31/2016.
4. In order to increase awareness of local food resources, the program's nutritionist will provide packets containing information about local food resources to 100% of home delivered meal participants by 9/30/2016.
5. All meal participants will be surveyed during the month of October 2016, and hunger/food insecurity questions will be scored and measured against 2015 data.
6. In order to improve health literacy among Home Delivered Meal participants, the Nutritionist will administer the Newest Vital Sign (NVS) Tool to 100% of those who score 6+ on the Nutrition Check Tool, indicating that they are high nutritional risk. Those who score 0-1 on the NVS will be provided additional nutrition education and counseling services on a 1:1 basis quarterly.

Transportation Services

Jefferson County provides transportation services to the elderly and persons with disabilities through the s85.21 Specialized Transportation Program. Persons seeking access to medical care are given priority services, as well as those needing help in meeting their nutritional needs. One additional driver was added to the driver pool in the fall of 2015.

REVIEW OF 2015 GOALS:

1. **Key Outcome Indicator: 100% of ride requests are safely met.** ***This goal was met.***
2. **Continue exploring ways to implement the Community Transportation Association of American (CTAA) Workgroup Recommendations.** *This goal is ongoing. Aging & Disability Resources Division staff take advantage of every local opportunity to discuss transportation issues. Decisions regarding the CTAA Workgroup Recommendations need to be made by the county's ad hoc transportation committee.*
3. **Attend all county transportation meetings.** *This goal was met.*

2016 Goals:

1. **Key Outcome Indicator: 100% of qualifying ride requests are met.**
2. 100% of unmet ride requests will be tracked to monitor community needs throughout 2016.
3. 100% of passengers will be surveyed to gauge satisfaction with services and to gather information about unmet needs by 6/30/2016.

Elder Benefit Specialist

Between 01/01/2015 and 12/31/2015, the Elder Benefit Specialist program served 862 clients and reported 1713 total contacts. The program tracked economic outcomes totaling $1,901,443 "federal" dollars, plus $174,320 "state" and $171,288 in "other" dollars for a grand sum of $2,247,051 in monetary impact for Jefferson County seniors.

In addition to the primary role to provide advocacy for Jefferson County seniors, the EBS program continued to host monthly Medicare workshops at the ADRC and 100% of 2015 evaluations for these workshops were positive.

REVIEW OF 2015 GOALS:

1. **Key Outcome Indicator: During the 12 months in 2015, the EBS program will continue to serve all individuals requesting assistance without subjecting them to a waiting list.** *This goal was met; the EBS program exceeded the number of seniors served in 2015 from the prior year.*

2. **<u>Special State/Federal Consideration for 2014/2015</u> A priority for the EBS will be providing education and outreach to seniors, providers, and state and federal legislators, summarizing how proposed changes related to Aging And Disability programs could affect seniors in Jefferson County and Wisconsin. (e.g. Provide factual data that supports the merits of the State SeniorCare prescription program, and how it coordinates with other insurances.)** *This goal was met. The State Pharmacy Assistance Program waiver extension has been approved by the federal government through 12/31/2018.*

2016 Goals:

1. **Key Outcome Indicator: During the 12 months in 2016, the benefit specialist programs will continue to serve all of the individuals requesting help without subjecting them to a waiting list.**
2. Expansion of the Seniors Out Speaking/ State Health Insurance Assistance Program by training one or more volunteers as a presenter for the Welcome to Medicare meetings.
3. Schedule an EBS in-service for new staff at the Social Security Administration field office in Waukesha.

<u>National Family Caregiver Support Program</u>

The National Family Caregiver Support Program provides caregivers with information about available services; assistance in gaining access to services; individual counseling, support groups and training; respite care to give them a break from providing care and supplemental services to compliment care.

<u>REVIEW OF 2015 GOALS:</u>

1. **A network of providers serving care recipients and care givers will be developed to address caregiver issues and needs.** *This goal was met in November of 2015. An existing group, known as the Community Care Alliance, was contacted and the membership agreed that caregiving needs and issues should be regularly discussed at meetings.*
2. **A Grandparent Support Group will be established for grandparents living with and raising their grandchildren.** *This goal was met.*
3. **Outreach efforts will include the development and distribution of a manual that explains the difference and similarities between the National Family Caregiver Support (NFCSP) and Alzheimer's Family Caregiver Support Program's (AFCSP).** *This goal was met.*

<u>2016 Goals:</u>

1. **Key Outcome Indicator: 100% of caregivers surveyed indicate that they were linked to helpful, appropriate services provided by or arranged for through the Alzheimer's and/or National Family Caregiver Support Programs.**
2. In order to strengthen and educate the county's caregiving network, information about caregiving will be shared quarterly with Community Care Alliance members by 12/31/2016.
3. In order to raise awareness about caregiver programs and resources available through the ADRC, marketing materials specifically for caregivers will be developed by 6/30/2016.

Adult Protective Services (APS) & Abuse/Neglect of Vulnerable Adults & Elders

The APS unit is responsible for ensuring that the health and safety needs of the elderly and individuals with disabilities are met, especially those with cognitive impairments when substantial risk is evident. APS services are mandated by state statute and are severely underfunded. Several different statutes establish the counties responsibilities in responding to these situations. The Human Services Department is the designated "lead agency" for receiving and responding to allegations of abuse or neglect.

Highlights from 2015

- 105 reports of abuse/neglect were received
  - 24 on Adults-at-Risk Age 18-59
    - 33.3% of reports were regarding self-neglect
    - 12.5% of reports were neglect by others
    - 16.7% of reports were physical abuse
    - 12.5% of reports were sexual abuse
    - 55.0% of reports were substantiated
  - 93 on Elder Adults-at-Risk Age 60+
    - 46.7% of reports were regarding self-neglect
    - 21.7% of reports were regarding financial exploitation
    - 5.4% of reports were emotional abuse
    - 21.7% of reports were regarding neglect by others
    - 47.7% of reports were substantiated
  - In the majority of cases referred, the abuse/neglect occurred where people live
  - Persons with Alzheimer's disease or a related dementia are in a high risk group
- 191 Annual Review of Protective Placements or WATTS reviews
- 48 Petitions for Guardianship
- 12 Petitions for Protective Placements

REVIEW OF 2015 GOALS:

1. **Key Outcome Indicator: 100% of referrals are responded to within the time frames contained in the statute; and case notation and legal time frames are met in 100% of cases referred.** ***This goal was met.***
2. **Maintain 100% compliance with established court time frames.** *This goal was met.*
3. **Respond to abuse/neglect referrals within 24 hours of the call. Complete a project to measure adherence.** *This goal was met.*
4. **When implemented, use ECHO software to document case notes/activities 100% of the time.** *This goal was not met as ECHO has not been fully implemented.*

2016 Goals

1. **Key Outcome Indicator: 100% of referrals are responded to within the time frames contained in the statute; and case notation and legal time frames are met in 100% of cases referred.**
2. Offer to provide or arrange access to memory screens in 100% of those cases where dementia is suspected but not confirmed.
3. Workers will attend quarterly I-team meetings and work on the ***Hoarding Initiative.***

BEHAVIORAL HEALTH DIVISION

"Providing evidence based treatment programs that are recovery oriented, trauma informed, person centered, and responsive to the needs of our citizens."

The Behavioral Health Division of Jefferson County Human Services has developed comprehensive programs that promote individual recovery while offering evidence based treatment options. We offer an integrated, county staffed, service delivery system. County provided programs include the Mental Health and AODA Outpatient Clinics, Intoxicated Driver Program, Comprehensive Community Services Program, (CCS), Community Support Program, (CSP), and Crisis/Emergency Mental Health Services. As part of our crisis services, we operate the Lueder House, a state licensed eight bed community based residential facility for adults with mental illness, who need crisis stabilization services.

Our Medical Director is a licensed adult and child psychiatrist. He is on site daily and available 24/7. He oversees all treatment programs and authorizes all necessary services. We also have 44 full time employees in a variety of roles on the four division teams.

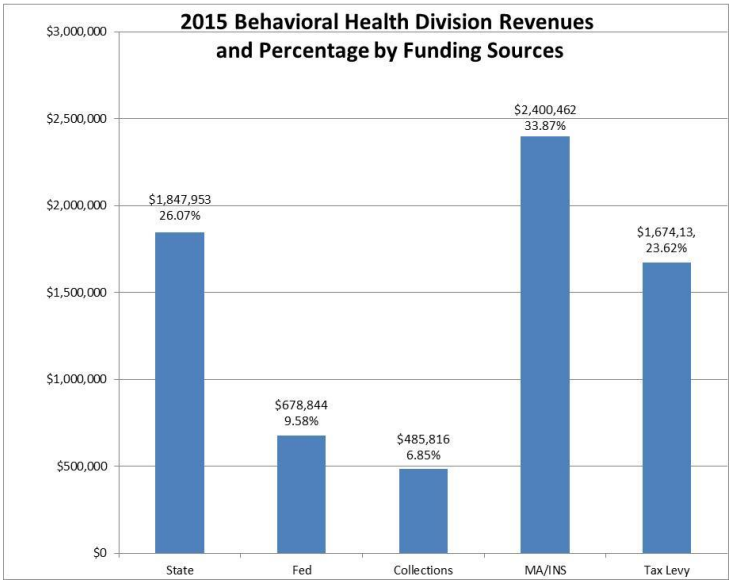
The Behavioral Health Division also contracts for evaluations, residential and inpatient services, specialized treatment services, and certified peer support specialist. Service contracts with providers set forth our expectations.

We remain steadfast in responding to the needs of citizens. We continue to see two significant trends. There is an increase in the number of citizens struggling with opiate addictions. Secondly, we continue to see an increase in the number of children struggling with complex trauma and mental health issues. We have expanded programs to address both these issues and they are described in the following team reports.

You will find below a bar graph summarizing the Division's revenue. Then each team area will be described with the key outcome indicator and goals shared.

Depreciation	**93,655**
County Indirect Cost	**107,528**
	201,183

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers (County levy).



Note: Family care contribuition of $625,097 is deducted since this is a HSD cost.

MENTAL HEALTH AND ALCOHOL AND DRUG OUTPATIENT CLINICS

~ Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into each person's plan~

The outpatient clinic staff strives to provide person centered and recovery focused services, and is committed to delivering evidence based practices. In 2015, the clinic again experienced an increase in the need for both mental health and substance use treatment.

The Mental Health, and Alcohol and Other Drug Abuse (AODA) Outpatient Clinics serve primarily adult Jefferson County residents with mental health and substance abuse concerns. In 2016 there were 256 new consumers entered into to the mental health clinic and 227 new consumers entered into the AODA clinic for substance abuse treatment. As the chart below indicates, the clinic provided mental health services to 718 individuals and Substance Abuse services to 393 individuals.

New for the Outpatient Mental Health Clinic was the addition of a Child Therapist in April of 2015. The Child Therapist treated a total of 21 children through the outpatient clinic and an additional 9 clients through the Comprehensive Community Services Program (CCS) ranging from elementary school aged children to high school.

	2008	2009	2010	2011	2012	2013	2014	2015
MH Clinic	294	332	478	541	615	690	661	718
AODA Clinic	246	207	217	225	288	334	327	393
Totals	540	539	695	766	903	1,024	988	1,111

Participants of the clinic are assessed for strengths and needs; the principles of hope and empowerment are integrated into clinic services. A treatment plan is created using the consumer's own strengths and resources to increase their potential for leading the life they want. Services are provided in the least restrictive manner; decreasing the disruption of the individual's life while still providing support for recovery services that include a wide array of evidence based practices.

The clinic staff consists of a Medical Director/Psychiatrist, eight full-time staff with masters' degrees in Social Work, Counseling or Psychology, one of whom works part-time in the county jail, as well as a Community Outreach Worker and the Clinic Supervisor.

The clinic is also responsible for overseeing civil commitments and in many cases, providing treatment for the individual. Under WI § 51, persons who are assessed to be dangerous to themselves or others and have a mental health disorder may be detained involuntarily. If the court determines that these persons need to be treated, they are placed under an order for treatment, typically for 6 months. The person can seek treatment from the outpatient mental health clinic, or if the person has other resources, by another area provider. Clinic staff provided mental health services to an average of 262 people per given month in 2015, approximately 17 of those individuals were ordered under WI § 51.45. In addition to those individuals who received treatment through the clinic, staff persons are also responsible for supervising the commitment period of all individuals on a Chapter 51 commitment and ensuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

Consumer Satisfaction

In 2015, the Outpatient Clinics conducted a random consumer satisfaction survey. The ROSI (Recovery Oriented System Indicators) measures the satisfaction of the participant and the degree to which its services are recovery oriented. The survey asks 42 questions regarding the participant's experiences in the past six months. The choice of responses range from strongly disagree to strongly agree and includes an option of does not apply to me. The questions rate 6 areas of service: Person Centered Services, Barriers to Success, Empowerment, Employment, Staff Approach and Basic needs. Consumers were asked to complete the anonymous survey by reception staff, prior to meeting with their clinician/counselor. The survey randomly sampled 24 clients.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 - Barriers	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Staff Approach	Scale 6 - Basic Needs
Average for All Consumers	3.4	3.6	2.0	3.6	3.9	1.4	2.7
% w/ Mostly Recovery-Oriented Experience	90.0%	87.0%	47.8%	100.0%	84.2%	81.8%	52.4%
% w/ Mixed Experience	10.0%	8.7%	39.1%	0.0%	5.3%	13.6%	33.3%
% w/ Less Recovery-Oriented Experience	0.0%	4.3%	13.0%	0.0%	10.5%	4.5%	14.3%

NOTE: MEANS CAN RANGE FROM A LOW OF 1.0 TO A HIGH OF 4.0. HOWEVER, ITEM WORDING FOR THE SHADED SCALES ARE NEGATIVELY PHRASED, SO A LOW MEAN REPRESENTS A MORE RECOVERY-ORIENTED EXPERIENCE (MEANING THE CONSUMER DISAGREED WITH THE NEGATIVE STATEMENTS). THE PERCENTAGES IN ROWS 3-5 HAVE BEEN ADJUSTED FOR SCALES 2 AND 5 SO THEY HAVE THE SAME MEANING AS FOR THE OTHER SCALES.

Consumer Survey Results

The outpatient clinic scored highest in providing a person-centered approach, empowerment and staff approach. 100% of all clients surveyed indicated that have at least one person who believes in them.

REVIEW OF 2015 GOALS:

1. **Key outcome indicators:** The outpatient clinic continued to track clinical outcomes by collecting client data via the Patient Health Questionnaire (PHQ-9) and Brief Addiction Monitor (BAM) assessment tools. The tools were administered during clients first sessions and throughout treatment a minimum of every 6 months. This tracking, reviewing and discussing clinical outcomes provided feedback about client progress during treatment and routinely and formally monitoring treatment responses. The goal for 2015 was to decrease PHQ scores by 2% and to increase BAM protective factors by 2%. This data was collected via a random sample of client scores. **These key outcome indicators were met.**

    a. **Patient Health Questionnaire (PHQ-9):** The PHQ-9 is a multipurpose tool utilized for screening, diagnosing monitoring and measuring the severity of depression. It rates the frequency of symptoms which factors into the scoring severity index. Question 9 of the tool screens for the presence and duration of suicidal ideation. A non-scored follow up question assigns weight to the degree to which symptoms of depression have affected the client's level of functioning.

b. **Brief Addiction Monitor (BAM):** The Brief Addiction Monitor is a 17-item monitoring tool that covers important substance use related behaviors to support measurement-based care and outcomes assessment. Of the 17 questions, 4 are specific to alcohol or drug use. The remaining questions address aspects related to substance use, recovery, and treatment that include a number of life areas considered important for a multidimensional assessment of substance abusing clients and include interpersonal relationships, psychological/medical problems, and finances. The BAM measures three summary factors: Recovery Protection, Physical and Psychological Problems, and Substance Use and Risk.

2. **Review, discuss and implement the Diagnostic and Statistical Manual-5**—the Clinic Supervisor, Medical Director and clinical staff persons reviewed and discussed the DSM-5 and implemented the new manual on October 1st, 2015. Weekly training sessions will commenced in May of 2015 that allowed for presentation of material, clinical case presentations and roundtable discussion of the DSM-5.
3. Continue **Motivational Interviewing Training** throughout 2015—Clinic staff continued training in motivational interviewing skills. The Clinic Supervisor monitored skills via individual supervision, clinical staffing's and observation of individual and group therapy sessions.
4. The clinic transitioned to **ECHO electronic health record system** and went live in ECHO on 12/1/2015. P.
5. Clinic staff participated in annual **compliance training**. Compliance is discussed in clinical staffing's and weekly supervision.
6. All clinic staff participated in **substance abuse training** to address the increase in opiate addicted clients treated by the outpatient clinic.
7. Clinic staff continued to utilize **cognitive behavior therapy** in treating clients, building on skills by discussing in clinical staffing's and weekly supervision.
8. In 2015, clinic staff captured consumer characteristic needs, service utilization and outcomes and report the data to the State of Wisconsin via the Program Participation System (PPS).
9. Throughout 2015, the clinic continued to participate in the Strengthening Treatment Access and Retention-Quality Improvement (STAR-QI) NIATx project with the Department of Health Services. The focus area was clinical outcome tracking on both the Patient Health Questionnaire (PHQ-9) and Brief Addiction Monitor (BAM) assessment tools. These assessments are administered to consumers every 3 months when the treatment plan is reviewed during the clinical review process.

Evidenced Based Practices for 2016

1. Motivational Interviewing-- Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=346). The clinic is utilizing this therapy protocol in both group and individual sessions. Clinic staff received intensive motivational interviewing training by MINT trainers throughout 2014 and 2015 and will continue with training throughout 2016.

2. Medication assisted treatment for opioid addiction via the use of Buprenorphine, Vivitrol and Naltrexone. (http://www.ncbi.nlm.nih.gov/books/NBK64164/). In 2015, the clinic ran four different treatment groups, specific for clients prescribed Buprenorphine. There was an average of 85 consumers in the Buprenorphine maintenance program.

3. Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It has been conducted in both group and individual sessions. Seeking Safety consists of 25 topics that can be conducted in any order. At this point, Seeking Safety is the most studied treatment for PTSD-substance abuse. Twelve outcome studies are completed, plus one dissemination study.

(http://www.seekingsafety.org). The clinic completed one round of group therapy utilizing the Seeking Safety material in 2015.

4. Cognitive behavior therapy (CBT) is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. (http://www.nacbt.org/whatiscbt.htm). All clinic staff persons were trained in cognitive behavior therapy and CBT is used in both group and individual sessions.

5. **Dialectical Behavior Therapy (DBT)** is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) and it is now recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders (http://behavioraltech.org/resources/whatisdbt.cfm).

2016 GOALS:

1. Clinic staff will use the **Columbia Suicide Severity Rating Scale (CSSR-S**) with all clients being served through the Outpatient Mental Health Clinic.
2. All Clinic staff will complete the **Collaborative Assessment and Management of Suicidality training (CAMS)**. CAMS is a therapeutic framework for suicide-specific assessment and treatment of a client's suicidal risk.
3. Two Clinic staff will complete training to become **Motivational Interviewing** trainers.
4. **Dialectical Behavior Therapy (DBT)** will be implemented in substance use treatment groups.
5. All Clinic staff will complete **annual compliance** training.
6. All Clinic staff will complete **Ethics and Boundaries training**.
7. The Clinic Supervisor will be trained in **Motivational Interviewing Skills Coding (MISC**) and clinic staff will submit tapes to the supervisor for coding.
8. The Clinic Staff will continue to utilize the **Brief Addiction Monitor (BAM) and Patient Health Questionnaire-9 (PHQ-9)** to track client progress in treatment. PHQ-9 scores will decrease overall and BAM protective factors will increase overall.
9. The Clinic staff will continue to participate in the Strengthening Treatment Access and Retention-Quality Improvement (STAR-QI) NIATx project with the Department of Health Services.
10. Clinic staff will continue to build on current knowledge of opiate addiction and how to best serve clients by participating in substance use treatment trainings throughout 2016.

INTOXICATED DRIVER PROGRAM

Public Intoxication Data for Jefferson County

Under Wisconsin statutes (51.45), a person incapacitated by alcohol can be placed under protective custody by a law enforcement officer and taken to an approved detoxification facility. Prior to discharge, the individual is informed of the benefits of further diagnosis and appropriate voluntary treatment. Upon discharge from such facility, our department is then responsible for arranging transportation for these people, whether it's via Human Services staff or communicating with and arranging for family to provide transportation. If there is a concern about the individual's well-being, department staff meet with the individual face to face to complete an assessment and the appropriate referral is made; which can be an emergency detention, voluntary hospitalization, residential treatment, intensive outpatient, or outpatient services to include individual and possibly group therapy.

Detoxification Data	2010	2011	2012	2013	2014	2015
Admissions	101	122	67	89	75	86
Individuals	75	91	54	67	58	70
Individuals with multiple admissions	8	16	5	12	14	9
Days	113.6	119.64	74	114	109	108
County Expenditures	**$44,778**	**$58,291**	**$28,642**	**$47,742**	**$48,500**	**$48,397**

All persons who enter detox services are offered substance use treatment. In reviewing individuals with multiple detoxifications admissions; 6 of the 9, participated in some level of substance abuse treatment.

Counties are mandated to provide an Intoxicated Driver Program (IDP) (HFS62). Each county is responsible for establishing and providing substance use assessments of drivers who have received an operating while intoxicated (OWI) conviction. The assessment can be ordered by the court or the Department of Transportation. The IDP assessor completes an assessment using the Wisconsin Assessment of the Impaired Drive tool (WAID). A driver safety plan is developed based on the results of the assessment. A person can be sent for either education if a substance use disorder is not found or treatment if a substance use disorder is found. The individual is responsible for completing the Driver Safety Plan within a year's time. Failure to complete the driver's safety plan will result in the driver's license being revoked or in some cases, remaining revoked. In addition to doing the assessments, the assessor is responsible for monitoring the individual's compliance with the Safety Plan. The clinic has one full time assessor.

In 2015, the IDP program completed 312 assessments and driver safety plans. Of those 312 assessments in 2015, 179 were first time offenders. This number accounts for 57% of the assessments. 52 were second time offenders, 42 had three lifetime OWI's, 19 had four lifetime OWI's, and 20 had five or more lifetime OWI's. Group Dynamics is a 24 hour education program for first time offenders. Multiple Offenders is a 36 hour education program for individuals with more than one OWI offense. 119 offenders were referred to Group Dynamics or to Multiple Offender Program. A total of 193 individuals were referred to outpatient substance abuse treatment.

Operating While Intoxicated Data

	2015
1st Offense	**179**
2nd Offense	**52**
3rd Offense	**42**
4th Offense	**19**
5th Offense or more	**20**
Total	**312**

COMMUNITY SUPPORT PROGRAM

"Advancing mental health services for people with severe and persistent mental illness"

The Jefferson County Support Program was developed in December of 1996 and began receiving clients in January 1997. This Community Support Program was certified on June 1, 1997 and is certified under HSS 63 as a Community Support Program. The program was audited by the state in May 2014 and was recertified for two years at that time. It will again be audited in May of 2016.

In its eighteenth year of operation the Jefferson County Community Support Program provided services to 158 consumers ranging in age from 8 to 75. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar, major depression and various anxiety disorders. In 2015, 17 consumers were admitted and 21 were discharged.

Jefferson County Human Services CSP has grown significantly. In 1998, it served less than thirty consumers, and employed five and a half staff. In 2014, the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/medical director; program assistant; two full time mental health technicians both of whom were also peer support specialists; one part time nurse; and eleven case managers/CSP professionals.

Community Support Programs in the state of Wisconsin have an extensive and well researched history. The original CSP started out of Mendota Mental Health Institute in the 1980's and is now known as ACT. The ACT model is considered an evidenced based practice for individuals with a severe and persistent mental illness and is now used on a nationwide and international basis. It has proven effective for reducing symptoms, hospital costs, and improving overall quality of life. The research has shown that for outcome measures to be similar for consumers in other CSPs it is important to have as much fidelity to the ACT model as possible. Jefferson County CSP continues to have very high fidelity to the ACT model and the team functions as an ACT team. It is believed that this leads to better outcomes for our consumers.

In accordance with the ACT model, the Jefferson County CSP has the capacity to function as a mobile in-patient unit. The program provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, opportunities for social interactions, individual and group psychotherapy, medication management and distribution, education and money management and budgeting, coaching in activities of daily living, including how to maintain a household and homemaking skills, crisis intervention, case management and supportive services to people with severe and persistent mental illness. All consumers in the CSP, at some time, have had acute episodes that have resulted in the need for frequent psychiatric hospitalizations and emergency detentions to institutes for mental disease. Consequently, in the past, their lives were disrupted and they were removed from their community of choice. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

The fidelity scale rating to the ACT model for the year was 107 as determined by the fidelity scale from the evidenced based toolkit for ACT implementation. Fidelity is rated on a five point scale, with five meaning full fidelity. We rated 1 in four areas this year related to staffing patterns. Full fidelity involves having two nurses per one hundred consumers and a full time vocational specialist. We only have six hours of nursing time to provide for the needs of one hundred fifty eight consumers over the year. There is also only very limited access to a vocational specialist at this time. There are no plans to address this currently. The second area involves the number of consumers we have attending monthly treatment groups for dual diagnosis. While we see an increase in substance abuse issues for the consumers we are currently serving, many of these individuals prefer not to engage in group treatment. The team continues to use Motivational Interviewing to enhance engagement and motivation when working with people dually diagnosed with substance abuse issues. In other areas, the team scored in a three to five range. This indicates very good fidelity to the model.

Jefferson County's CSP also provides consumers the evidence based practices of Illness Management and Recovery, Integrated Dual Diagnosis for those with substance abuse issues, Supportive Employment, Seeking Safety, Cognitive Behavior Therapy, Coping CAT, Trauma Focused-Cognitive Behavior Therapy, and Dialectical Behavioral Therapy. Consumers also are encouraged to complete Wellness Recovery Action Plans that specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

Close attention was again paid to tracking outcomes in the consumer database to monitor for outcome measures. In 2015, ninety two emergency room visits were tracked for CSP consumers. This averages .52 visits per consumer in the CSP in 2015, up from .31 ER visits per consumer last year. This is likely due to an improvement in tracking forms.

Twenty three Community Support Program consumers accounted for 37 tracked hospital stays in 2015, an increase in admissions for 2015. This accounted for 337 hospital days for the year. Thirty five consumers accounted for 78 tracked admissions to the Lueder Haus in 2015 for 761 days. Both hospital days and Lueder Haus days were increased this year as several people did not have residential placements to return to upon discharge and were there for longer stays. We continue to make greater use of the Lueder Haus as we focus on providing support in the least restrictive setting, moving away from the hospital. Thirty seven percent of the participants in the program have integrated primary health care with the treatment team either taking them to medical appointments or coordinating treatment.

In 2015, the CSP consumers met 71% of their treatment goals that were identified in their individualized recovery plans. In 2014, 68% of identified goals were met. This will be an area that will continue to be monitored as an outcome measure for 2016.

	Emergency Detentions of Consumers in CSP	Number of Consumers Admitted Following a Recent Emergency Detention	Number of CSP Consumers Returned to a More Restrictive Setting
2013	11	5	No data
2014	10	7	12
2015	7	9	3

This data will continue to be reviewed and tracked in 2016, with an emphasis on reducing the utilization of the emergency rooms, hospitals, and Lueder Haus while increasing the percentage of recovery plan goals met.

We again decided to implement the Recovery Oriented System Inventory (ROSI). The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self-report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation.

Consumers of the CSP were sent a ROSI survey to complete anonymously. Fifty seven consumers completed this survey up from thirty eight last year. The following chart further explains the ROSI and summarizes the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

Means and Percentages for ROSI Consumer Survey Scales							
	ROSI Overall Mean	**Scale 1 - Person Centered**	**Scale 2 - Barriers**	**Scale 3 - Empower**	**Scale 4 - Employ**	**Scale 5 - Staff Approach**	**Scale 6 - Basic Needs**
Average for All Consumers	3.2	3.4	1.9	3.4	2.7	1.5	3.0
% w/ Mostly Recovery-Oriented Experience	65.4%	82.7%	43.4%	83.0%	39.5%	76.0%	70.6%
% w/ Mixed Experience	32.7%	17.3%	52.8%	17.0%	44.7%	20.0%	21.6%
% w/ Less Recovery-Oriented Experience	1.9%	0.0%	3.8%	0.0%	15.8%	4.0%	7.8%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.)

The means from 2015 continue to show positive results. These results continue to indicate that consumers feel empowered by CSP staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized. The score for employment is lower and likely results from lack of available services.

The results were consistent with the results that we collected in 2014.

It is believed that due to these combined efforts the Jefferson County CSP was successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.

Some of the specific accomplishments for the year 2015 include:

1. Eleven consumers, who were on Chapter 51 orders, successfully completed their court requirements.

2. Two consumers resumed managing their own money as their skills were enhanced and the protective payeeships were dismissed.

3. Twenty four percent of the adult consumers worked in a job of their choosing.

4. Twenty six consumers served the community through volunteer work through such places as Fort Atkinson Memorial Hospital, St. Vincent's, nursing homes, Food pantry, CSP consumer council, Horizons, and Twice as Nice.

5. Three consumers pursued educational goals. One of the consumers attended Edgewood College in Madison and graduated with a teaching degree in the spring of 2015. One consumer began classes at MATC. One attended UW- Whitewater.

6. One consumer moved out of her adult placement and into her own living arrangement.

7. Seven goals were met from last year's report. These will be reviewed below in detail.

REVIEW OF 2015 GOALS:

In 2015, the CSP chose as its key outcome indicator to focus on increasing the percentage of treatment plan objectives met for the consumers in their recovery plans. It was felt that focusing on this indicator would assist both in increasing the effectiveness of the staff in working with consumers as well as the consumer's satisfaction with services and progress in recovery as they are achieving the things they have identified as important. For the 2015 year, the CSP key outcome indicator was to increase the percent of treatment plan objectives accomplished to 72%. The team achieved a 71% of goals met without controlling for the consumers who were experiencing significant relapse symptoms. The overall percentage of treatment plan objectives accomplished in 2014 was 68% so there was a 3% increase in goal achievement. All CSP staff attended the Motivational Interviewing training and each staff has been applying their skills when working with consumers. All have been utilizing Cognitive behavioral therapy skills as well to assist treating individuals with an array of diagnosis. The CSP team will continue to strive to maintain the percent of recovery plan objectives accomplished to 70% for 2016.

There were eight program goals established for 2015.

Goal number one for 2015 was: Meet key indicator outcome of: Increase the rate of completion of treatment plan objectives from 68% to 72%. The team achieved a 71% completion rate for treatment plan goals met.

Goal number two for 2015 was: Train all staff in Echo and implement the new electronic documentation system. The program assistant and CSP supervisor attended multiday trainings led by the Echo staff. All staff were trained in Echo in weekly team meetings and have logged on regularly to improve their skills. Due to system issues Echo was not implemented in 2015.

Goal number three for 2015 was: Train all new staff in motivational interviewing and practice motivational interviewing skills in team meetings. One of the CSP staff was trained as an MI coach in 2015. Booster sessions were held to increase skills in components of motivational interviewing and all staff attended. New workers were trained in motivational interviewing and attended the sessions as well. Each staff submitted a tape for coding by the MI trainer and received feedback on their session. Motivational Interviewing goals were set in each staff's performance evaluations. Ways to utilize motivational interviewing were identified in team meetings and individual supervision sessions. Several team meeting were held to review skills and enhance knowledge of MI.

Goal number four for 2015 was: Participate in the trauma informed care grant and further train staff in this area. Staff were invited to the kickoff event for the trauma informed care kickoff event where the project was overviewed and trauma principals and effects were discussed. CSP supervisor participated in the Tier 1 group for the trauma project and attended several multiday trainings in Trauma focused-Cognitive Behavioral Therapy. Materials were brought back to implement with the children in CSP. Several lunch and learns were held throughout 2015 dealing with trauma and staff attended these as well.

Goal number five for 2015 was: Implement a weekly clinical training team meeting for CSP staff to further expand evidence based practices in CSP. A weekly Dialectical Behavioral Therapy supervision group has been established on Fridays led by the Human Services Director, CSP supervisor, and Clinic Supervisor. Materials have been presented for implementing DBT with children and adults. All CSP workers have been invited to attend and several attend on a weekly basis. Materials on mindfulness have been presented in team meetings and resources have been discussed as well. All CSP staff were also trained in the evidenced based Columbia Suicide Training Tool.

A second clinical review meeting was added with Dr. Haggart weekly on Thursdays to review the treatment for the children and adolescents in CSP.

Goal number six for 2015 was: Implement two projects in 2015. This goal was met. The first project involved creating an outcome monitoring sheet for the children and adolescents to better track and monitor progress for each child.

The second project involved changing the medication system to better track the delivery of medications in CSP to the staff, the consumers, and the disposal of untaken medications. Several new forms were created for the project. All medications are now checked out when the staff takes them from the storage area. The consumer is asked to sign for all medication that is dispersed. All medications that are turned over for disposal are recorded and signed out as well.

Goal number seven for 2015 was: Expand the opportunities for peer support services in CSP. A CSP consumer who was certified as a peer support specialist was hired through NAMI Waukesha. Her services were contracted through NAMI and she currently provides twenty hours of service in CSP weekly. A master's position was hired last year and this individual is also certified as a peer support specialist. There are currently three certified peer support specialists employed full time on the CSP team.

Goal number eight for 2015 was: Explore and implement more evidence based practices to the children in CSP services. The supervisor in the program attended trainings and participated in an initiative to implement Trauma Focused–Cognitive Behavior Therapy an evidenced based practice for children and adolescents with Post Traumatic Stress Disorder. The material from the book Dialectical Behavior Therapy for Adolescents was reviewed in a weekly DBT supervision group. DBT is an evidenced based treatment for individuals with multiple problems including suicidal adolescents, individuals that self-harm, or individuals with substance use issues or eating disorders. Collaborative Problem Solving was explored as an evidenced based practice with explosive children with difficult behaviors.

2016 GOALS:

1. **Key Outcome Indicator**: Achieve 72% treatment plan goal objectives met among CSP participants.
2. Train all staff in CAMS, an evidenced based practice for individuals who feel suicidal.
3. Continue to provide opportunities for the staff to increase their skills in motivational interviewing and have all staff submit tapes for coding and feedback.
4. Identify ways to better screen individuals for trauma and PTSD when they are admitted to the program.
5. Discuss ways to enhance the social connections and recreational opportunities for individuals in the CSP.
6. Implement two NIATx projects in 2016.
7. Utilize the Colombia Screening Tool for Suicide with all consumers and complete the long screen to better identify the risk factors of each consumer in the CSP.
8. Explore Aggression Replacement Training for children and adolescents in the program for individuals with aggressive behaviors.
9. Add a new staff position for 2016 to further improve access to CSP services.
10. Identify people in the program at high risk for readmission to the hospital, Lueder Haus, or who frequently utilize emergency room services to review services and attempt to identify plans to improve outcome measures in this area.

COMMUNITY RECOVERY SERVICES

"Providing qualifying consumers with services to move forward in their recovery goals"

Community Recovery Services provide qualifying consumers with services to move forward in their recovery goals. Services that can be provided are peer support, employment services and community living supportive services. The program is funded through Medicaid. In 2015, ten consumers were served in the program. There were three admissions and one discharge. All ten consumers received community living supportive services. All of the consumers received supports in adult county residential placements. The one consumer who was discharged was able to move to her own independent apartment and was discharged from the CRS program to Dane County supports. Although the program remains small in size, we have seen impressive outcome measures in the past several years for individuals returning to live more independently in the community.

In 2015, the program focused on quality assurance and monitoring in regards to the recovery notes provided by CRS supports. This included multiple trainings of programs and direct service providers in the note format and proper provision and documentation of CRS services. Quality was monitored and frequent contacts were made with providers to resolve problems. A financial and clinical audit of the program was conducted in fall of 2015 with 100% compliance with state requirements. Audits were done of the CLSS provider employee staff records by CRS in 2015.

A ROSI survey was implemented this year with the following results. Five of the ten consumers responded to the survey. A more detailed explanation of the ROSI survey can be found in the CSP section of this annual report.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 - Barriers	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Staff Approach	Scale 6 - Basic Needs
Average for All Consumers	3.5	3.6	1.4	3.9	2.4	1.3	2.8
% w/ Mostly Recovery-Oriented Experience	100%	100%	80%	100.0%	67.7%	100%	80%
% w/ Mixed Experience	0.0%	0.0%	20%	0.0%	0.0%	0.0%	0.0%
% w/ Less Recovery-Oriented Experience	0.0%	0.0%	33.3%	0.0%	33.3%	0.0%	20%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.)

The respondents agreed that they felt empowered by the program services and liked the staff approach. They continue to experience barriers in meeting basic needs. The just as in the CSP ROSI, the consumers identify a need for better employment services. The CRS team will focus next year on obtaining a larger sample size of

participants completing the ROSI survey to obtain additional input into how the program is meeting the consumer's needs.

In 2016, options for expanding the program will be explored and a continued focus will be made on ensuring the quality of provider services and documentation while maintaining compliance with the state regulations. The program will strive to discharge at least one individual from adult residential placement services to begin living independently in the community.

COMPREHENSIVE COMMUNITY SERVICES PROGRAM (CCS)

"Providing qualifying consumers with services to move forward in their recovery goals"

The Jefferson County Comprehensive Community Services Program (CCS) completed its seventh full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license has been renewed every two years, most recently March 2014.

Program Description

CCS is a voluntary, recovery-based program that serves children (0-18), adults (18-62) and senior citizens (63-100) with serious mental health and/or substance abuse disorders. As stated on the State's Bureau of Mental Health Prevention, Treatment and Recovery website, CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery.

CCS offers an array of psychosocial rehabilitative services which are tailored to each individual consumer. These services include: screening and assessment; service planning; service facilitation; diagnostic evaluations; medication management; physical health monitoring; peer support; individual skill development and enhancement; employment related skills training; individual and/or family psychoeducation; wellness management and recovery/recovery support services; psychotherapy; substance abuse treatment; and non-traditional or other approved psychosocial rehabilitative services deemed as necessary.

Project YES! (Youth Empowered Solutions)

In October 2014, Jefferson County Human Services was awarded a five year grant of $328,314, per year, to become a local pilot site to increase, as well as enhance, services related to youth/young adults who are at risk of, or are experiencing mental health and substance use problems in Jefferson County. The State of Wisconsin was awarded the grant from Now is the Time-Healthy Transitions (NITT-HT)/Substance Abuse and Mental Health Services Administration. Funding from the State of Wisconsin became available in February 2015.

The Project YES! grant focuses on three goals: 1.) To expand the number of youth/young adults (Y/YA) aged 16-25 who receive age appropriate, culturally competent and evidence-based behavioral health treatment and support within sub-recipient geographic areas. 2.) To increase awareness of providers, parents, youth and young adults on the mental health/substance use issues and needs of Y/YA aged 16-25; and 3.) To develop and implement local and state policies and practice changes that will improve Y/YA engagement as well as promote successful transitions to adulthood. To make the program sustainable, the State of Wisconsin Consultant Team decided it would be best to implement the new concepts, framework and evidenced based practice modifications within the CCS program due to CCS having similar philosophies and best current practice by providing community psychosocial rehabilitation services to youth/young adults.

Key Outcome Indicators

For the 2015 year, the CCS goal was to increase the percent of recovery plan objectives accomplished to 72%. The overall percentage of recovery plan objectives accomplished in 2015 was 74.4%. Seventy Seven percent of the objectives for children were accomplished (9% increase from 2014) and Seventy Four percent of objectives were met by adults (16% increase from 2014) in the program. All CCS staff attended the Motivational Interviewing training and have been applying their skills when working with consumers. Three CCS staff did not receive the MI Basics training, as they were hired after these dates. All staff have been utilizing Cognitive behavioral therapy skills as well to assist treating individuals with an array of diagnosis. Many staff utilize Dialectical Behavioral Therapy (DBT) skills during treatment. Two CCS staff participate in a DBT consultation group at our agency. Throughout the 2015 year, the CCS had two seasoned staff leave the agency, thus two new staff were hired. In February 2015 CCS hired one full time Project YES director and one full time Project Yes! service facilitator. At the end of 2015, The CCS team started interviewing for two newly created positions to start in 2016. The CCS team will strive to maintain the percent of recovery plan objectives accomplished at 72% for 2015.

General data

During 2015, 106 consumers ranging in age from 6 to 72 received services. This is an increase of the number of people served in 2014 by 20. Throughout 2015, 49 new consumers were admitted and 30 consumers were discharged. Of the consumers admitted to the program, 32 were children and 17 were adults. Of the consumers discharged, 13 were children and 17 were adults. Of the 30 consumers who were discharged, 10 moved from our geographic service area, 7 recovered to the extent that CCS level of services were no longer needed, 8 consumers decided to withdraw from services, 2 consumers needed a higher level of care, 1 consumer became incarcerated and 2 consumers passed away. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, reactive attachment disorder, attention deficit hyperactivity disorder, obsessive compulsive disorder, conduct disorder Oppositional Defiant Disorder and substance use disorders.

The CCS staff consists of a Psychiatrist, CCS Service Director, and a Project Yes director. As of January 2015 there were 6 full time CCS Service Facilitators, one full time Project Yes transition facilitator, one full time psychosocial rehabilitation provider and one rehabilitation worker assigned to CCS for less than 20 hours per week.

Consumer Satisfaction

The CCS program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 19 adult respondents this year which was an increase of 10 from 2014. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff is doing well in these areas. These two areas remain below a mean score of 2. This year's ROSI showed an overall mean of 3.4 compared to the 2014 overall mean of 3.3. 73.3% of consumers had a mostly recovery oriented experience, which was comparable to the 2014 overall mean of 77.8%. A theory as to why this percentage has decreased to 73.3% is the result of two long term staff leaving the agency in 2015. The CCS program continues to focus on training newly hired CCS staff in person centered planning, treatment and recovery oriented approaches with consumers. The CCS program continued to utilize a part time contracted job developer trained in IPS to assist consumers in their pursuit of obtaining employment. This worker maintains strict fidelity to the evidenced

based model and has been trained in the Dartmouth IPS model. In 2015 there was turnover in staff for this position, thus some consumers had four different employment specialists throughout the year. The CCS program will continue to search for more vendors to assist with employment. The CCS region (Jefferson, Rock and Walworth) are focusing efforts on increasing the percentage of consumers who are employed or volunteering to 40% by July 31, 2017. This will include adolescents and adults.

Means and Percentages for ROSI Consumer Satisfaction Survey Scales

	ROSI overall mean	**Scale 1 person centered**	**Scale 2 Barriers**	**Scale 3 Empowerment**	**Scale 4 Employment**	**Scale 5 staff approach**	**Scale 6 Basic needs**
Average for all consumers	3.4	3.7	1.7	3.4	3.0	1.3	3.1
% with mostly recovery oriented experience	73.7%	89.5%	57.9%	89.5%	40.0%	84.2%	64.7%
% with mixed experience	26.3%	10.5%	42.1%	10.5%	60.0%	15.8%	29.4%
% with less recovery oriented exp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.9%

The CCS program conducted a Youth Consumer survey for youth aged 13-17 to measure the consumer satisfaction of our program regarding a positive experience. We had 15 Youth respondents which was an increase of 10 from 2014. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, Satisfaction, Participation, Access, Culture, Outcomes, and Social Connectedness. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 1.0 represents a more positive experience. All categories remain below a mean score of 2.0 which is a slight improvement from the 2014 mean average of 2.3.

Means and Percentages for YOUTH (aged 13-17) Consumer Satisfaction Survey Scales

	YOUTH overall mean	Scale 1 Satisfaction	Scale 2 Participation	Scale 3 Access	Scale 4 Culture	Scale 5 Outcomes	Scale 6 Social Connectedness
Average for all consumers	1.7	1.7	2.0	1.8	1.4	2.0	1.5
% with more positive experience	93.3%	93.3%	73.3%	80.0%	100.0%	80.0%	93.3%
% with mixed experience	6.7%	6.7%	20.0%	6.7%	0.0%	13.3%	6.7%
% with less less positive experience	0.0%	0.0%	6.7%	13.3%	0.0%	6.7%	0.0%

The CCS program conducted a Family survey for children aged 12 and younger to measure the family satisfaction of our program regarding a positive experience. We had 4 family respondents which was an increase of 3 from 2014. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, Satisfaction, Participation, Access, Culture, Outcomes, and Social Connectedness. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 1.0 represents a more positive experience. All categories remain below a mean score of 2.0 which is a slight increase from the 2014 mean average of 1.0. However, all four families rated their experience as more positive with an overall mean of 100% which was the same in 2014.

Means and Percentages for FAMILY (aged 12 & younger) Satisfaction Survey Scales

	overall mean	Scale 1 Satisfaction	Scale 2 Participation	Scale 3 Access	Scale 4 Culture	Scale 5 Outcomes	Scale 6 Social Connectedness
Average for all consumers	1.4	1.3	1.6	1.1	1.0	2.0	1.1
% with more positive experience	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% with mixed experience	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% with less positive experience	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Monetary benefits

In 2015 the CCS program was reimbursed $914,496 from Medicaid for services provided to consumers. This is an increase of $509,667.53 from 2014. CCS also received a reimbursement of $161,702 for the reconciliation from the 2014 year. In addition, CCS received an MA reimbursement from 2014 of $8,728. This will continue to be a focus of our program in the next year to assure we are recouping the maximum amount of funds possible. We are focusing on compliance, collaborative documentation, and increasing our network of community providers. Some of the challenges of this year for the CCS team were the loss of two seasoned CCS staff and needing to replace those positions. This involved recruiting, interviewing and training new staff. Although this was unfortunate for the CCS team, the team was still able to increase the number of consumers serviced in 2015 by 19 individuals.

Children

In 2015, the CCS program served 57 children, ages 6 to 17; of these children, 32 were males and 25 were females. Thirty-two children were admitted to CCS and 13 were discharged. Of the thirteen discharged, 5 children moved out of the county, 4 children chose to withdraw from the program, 3 children met their discharge criteria, and one child needed a higher level of treatment. Forty-seven of the children resided at home all year or with a relative; three children moved from out of home back home or to a relative's home and nine resided in a group home. Of these nine children, three resided at the group home for the 2015 year, and six were there part of the year. Of the six who resided in a group home for part of the year, two moved to a residential facility, and one child was reunified with parents. Five children enrolled in CCS resided for part of the year in a foster home. Two of these five children were reunified with a parent or relative. One child resided in a foster home and treatment foster home while enrolled in CCS. One child resided in a treatment foster home part time.

During 2015, 4 children had a mental health commitment order. Two of the children were able to end their mental health commitment order. In regards to Child Protective Services (CPS) orders, there were 14 children on orders. Nine of the children's families began a CPS order; 5 were currently on an order and 3 orders ended. There were 15 adolescents on a Juvenile Justice Order. Six adolescents began an order in 2015, 9 were already on an order and 7 adolescents orders ended. Three adolescents were on a Deferred Prosecution agreement (DPA). Two adolescents started a DPA and one adolescent was currently on a DPA. One DPA ended in 2015. One adolescent started a consent decree in 2015. Two adolescents age 17 were on adult probation. One served 6 days in jail and the other served 128 days in jail.

There were 17 children/adolescents with police contacts with a total of 44 police contacts, which is a decrease of 10 contacts from 2014. Twelve children/adolescents had one police contact during the year. Five children/adolescents had between four and ten police contacts each, with one adolescent having a total of 10 police contacts for the year; one had seven police contacts; one had six police contacts; one had five police contacts and one had four. Four adolescents spent time during the year in secure detention. There was a total of 59 days in Secure detention overall. One of the adolescents had a total number of 49 days in secure.

Of the 51 children in CCS, ten adolescents received suspensions from school during the 2015 year which totaled 29 suspension days. One child was enrolled in school partial days, to full days, to then homebound instruction. Four children went from full time to partial days. Five children attended school partial days due to behavior and mental health issues. Three children successfully progressed from partial days to full days and three children were able to go back to school for full days in 2015.

There were 12 children admitted for psychiatric hospitalizations. Nine of the children had voluntary admissions which totaled 207 days. Of these voluntary admissions, one child had seven separate admissions totaling 100 days. There were 3 children who were admitted involuntarily to the hospital. Two of the children were emergency detained for a total of 50 days. The other child was returned to a more restrictive setting per the

chapter 51 court order which totaled 7 days. The total number of involuntary hospital days decreased by 139 days from 2014.

CCS had five adolescents who were connected to employment. Two were applying for part time work, two were employed part time and one worked fulltime over the summer.

Youth/Young Adults (ages 16 to 25)

In 2015, Project YES! staff served 19 consumers between the ages of 16-25. These consumers enrolled into CCS so they are already included in the children and adult numbers. Outreach is a major component of the Project YES! philosophy to help engage youth in treatment services, as well as increasing awareness of mental health issues/substance use issues and needs of youth/young adults. Staff from PY! contacted 303 individuals through outreach efforts. This includes youth/young adults, parents, community members, school staff, police departments, various coalitions, children's teams within JCHS, resource fairs, etc. Through ongoing outreach efforts, Project YES! staff screened 102 youth/young adults for mental health needs. Project YES! defines screening as coming in contact with youth/young adults having a mental health and/or substance use disorder and being between the ages of 16-25. Twenty two of the youth who were screened were referred to mental health services, while 19 enrolled in CCS programming.

In July 2015, the State of Wisconsin coordinating team coordinated a Project YES! Kickoff in Outagamie County, where community members were invited to be introduced to Project YES! philosophies, partnering and supporting youth/young adults while creating a framework. Three CCS youth, as well as two Jefferson County Peer Support Specialists attended the event.

Project YES! philosophy also promotes healthy activities for youth. In August 2015, youth/young adults were invited to attend events hosted by PY!. Four Jefferson County PY!/CCS youth attended a focus group with the other local pilot site, Outagamie. Outagamie had one youth participate. This gave the youth a chance to voice their ideas and desires on what things are important to them when engaging and receiving mental health and/or substance use issues. Youth were able to provide input on what titles they would like to call CCS Transition Service Facilitators, what clothing they would like the service facilitators to wear when meeting with youth/young adults in public, as well as ideas on where they could connect with other youth/young adults with mental health needs in the community. After the session, evaluations were collected about what the youth liked about the gathering, what they didn't like and if they would like to meet again. All five of the youth reported they would like to have future events coordinated by Project YES!/CCS staff with staff input.

In October 2015, four Project YES!/CCS participants also got the opportunity to go to a Pumpkin Farm to work on social skills and complete a healthy activity to promote wellness and balance by using coping skills in the community. They were also offered a choice as to where they wanted to go to spend the day. They enjoyed the activity of the corn maze, as it allowed them to utilize problem solving skills and appropriate social skills. The youth/young adults were physically active as they also utilized coordination skills by riding oversized bikes, swinging, and going through tunnels.

In December 2015, Project YES!/CCS recognized the importance of female youth/young adult connections with other youth/young adults. Project YES!/CCS staff held a female group where participants were able to make a craft of their choice. Two female participants attended with the youth coordinator from the State of Wisconsin. The young adults made a connection with each other and found common interests to talk about. It also assisted one of the young adults who had been isolating due to moving into Jefferson County and not having a network of supports.

At all activities, youth and young adults are encouraged to start working toward group cohesion, advocacy and enhance leadership skills when comfortable

Adults

In 2015, the CCS program provided services for 49 adults aged 18-72. Of these adults, 14 were males and 35 were females. Thirty-three consumers lived in their own apartment/home or with family. Two consumers resided in a supervised apartment. One individual moved from a supervised apartment to a group home. One consumer moved from their own home to a hotel. One consumer moved from a foster home to their own home. One adult moved from residing with friends to living with family. One consumer moved from an emergency stabilization facility to an inpatient treatment facility. One individual was homeless and one consumer resided with friends and family. Two consumers resided in a sober living home. One consumer resided with friends, in a hotel and eventually moved to a supervised apartment for more supports funded by Care Wisconsin.

In 2015, 17 adults were admitted to CCS and 17 were discharged. Of the people discharged, one person was transferred to the Community Support Program (CSP) due to increased symptomology and the need for additional services. Five individuals moved out of county, four individuals withdrew from services, one consumer was incarcerated, two consumers passed away and four individuals were discharged for successfully meeting discharge criteria.

There were nine voluntary psychiatric admissions involving eight consumers. One adult had two admissions. The voluntary admission days totaled 53 days. There were two involuntary psychiatric admissions, as two consumers were emergency detained totaling 10 days. One adult was voluntarily admitted to a residential AODA facility totaling 91 days. Three adults were on a Chapter 51 Mental Health Commitment Order. Two of these consumers were already on an order and one consumer started an order. One consumer was able to successfully end the order. Six adults in CCS utilized a crisis stabilization facility. There were 13 admissions with one consumer have 5 admissions, one consumer having 3 admissions and one consumer having two admissions. The total number of days for the crisis stabilization services totaled 77. There were 10 consumers who utilized the ER for a total of 24 visits. One consumer had 11 admissions, one consumer had 3 admissions and two consumers had two admissions each. Of the 10 consumers who were admitted to the ER, two of them are enrolled in Care Wisconsin.

CCS had twenty-two adult/elderly consumers who were connected to employment. Two were applying for employment. Twelve consumers were employed part time and three consumers worked full time. One consumer had been applying and then decided they were no longer interested in employment. One consumer was working full time and went down to part time. One consumer was applying for work and started working part time. One consumer was applying for work and started working full time. One consumer was employed part time and moved to full time employment.

Elderly

The CCS program served three consumers who were considered elderly (age 63+). One of these consumers needed a higher level of care and was discharged to a different program within the agency and one consumer passed away.

Recovery Plans/Reviews as it pertains to all CCS consumers

Consumer recovery plans are reviewed every six months. Thirty-three consumers participated in the CCS program long enough to have two recovery plans in 2015. Of these 33 consumers, 74% of their objectives were met. Seven consumers completed 100% of the objectives for both recovery plans. Thirty-Six consumers were enrolled long enough to have only one recovery plan in 2015. Eighteen of these consumers met 100% of their objectives for their only recovery plan in 2015

The children met 77% of their objectives throughout 2015. Sixteen children met 100% of their objectives for one six month recovery plan period. Three children met 100% of their objectives for the entire 2015 year.

Twenty-two children did not have a recovery plan review during 2015 due to their admission dates and or discharge dates. Two children did not meet any of their objectives. Of these two children, one was on a Juvenile Justice order and spent time in secure detention, respites at foster homes and groups homes and was eventually placed outside of the home to a group home.

The adults/elderly met 74% of their objective throughout 2015. Thirteen adults/elderly were able to complete 100% of their objectives for a six month period. Four adults were able to complete 100% of their objectives for the entire year. Sixteen adults/elderly did not have a recovery plan review during 2015 due to their admission dates and/or discharge dates.

We continued to use person centered planning when doing recovery plans. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural supports. Consumers have reported feeling in charge of their services and being able to direct the team in their needs. Family members and providers feel that they can easily read and understand the plan. Family members and other natural supports feel more connected as they are written into the plan providing services to the person. The plans also inform the consumer of the services they are to receive. This increases accountability since everyone on the team knows his or her responsibility in assisting the consumer in building recovery.

Additional service providers

The CCS program contracted with 14 organizations throughout 2015. Seven of these organizations were new CCS contracts in 2015. CCS developed a contract with one more agency; however this agency did not sign the contract.

- Thirteen individuals provided contracted therapy services. These individuals provided a mix of agency and in-home individual and/or family psychotherapy, psychoeducation, service planning, service facilitation and some diagnostic evaluations.
- Two individuals provided diagnostic evaluations and recommendations.
- Three certified peer specialists assisted the CCS program throughout 2015. These trained peers provided support and advocacy for persons in their journey of recovery. Two of these three peer specialists resigned.
- One individual provided psychosocial rehabilitation services on an in-home basis to assist consumers with mental health and substance use concerns.
- CCS continued to utilize contracted job developers trained in IPS to assist consumers in their pursuit of obtaining employment. These workers maintained strict fidelity to the evidenced based model and have been trained in the Dartmouth IPS model. There was high turnover at this organization, thus some consumers received services from four different employment specialists throughout 2015.

Four of the new contracts that were signed by CCS were not utilized during 2015. One was developed by Jefferson County CCS and referrals were made in 2015 but the consumers were placed on a wait list. We anticipate that in 2016 this particular provider will be able to service CCS consumers at the start of the year for in-home therapy services. The remaining three contracts were either developed or existing in Walworth County or Rock County. Jefferson CCS consumers in 2015 were offered services at these organizations and referrals were made to one of the providers. We anticipate that CCS consumers will be enrolled for services with this provider for individual skill development and enhancement services in 2016. Because therapists, psycho-social rehabilitation workers, peer support specialists and employment specialists employ psychosocial rehabilitation practices, their services were billable to Medical Assistance through the CCS program.

2015 Evidence Based Practices

CCS provided the following evidenced based practice groups; Seeking Safety Group for adults at JCHSD and Dialectical Behavior Therapy Skills Based Group for adolescents at the Jefferson High School and Watertown High School. Individually, people were offered Pyscho-education, Illness Management and Recovery, Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), Coping Cat and Supported Employment. CCS families also participated in Functional Family Therapy (FFT).

The CCS team was fortunate to have three CCS service facilitators participate in a yearlong learning collaborative addressing Trauma Focused Cognitive Behavioral Therapy for children ages 3-17. Two staff from the outpatient clinic also participated in this learning collaborative and provided this evidence based treatment to many CCS consumers. Eight contracted therapists in the community participated in this training as well and have been servicing CCS consumers with this treatment.

CCS parents, caregivers, foster parents and one CCS staff participated in an 8 week training facilitated by a foster parent utilizing the Trauma Informed Care approach to better assist them with understanding the effects of trauma on children ages 3-17 and ways to better manage the symptoms/behaviors exhibited by the children.

CCS Coordinating Committee

The CCS Coordinating Committee is currently comprised of consumers, staff, parents and individuals from the community. The committee meets quarterly at Human Services for at least one hour. The committee continues to focus on recruitment and retention of members and reviewing policy and procedures of the CCS program.

The CCS Coordinating Committee submitted the following recommendations for the CCS program in 2015:

- A support group on sexual abuse/PTSD **(CCS Co- facilitated a seeking safety group with the mental health outpatient clinic for adult females to address PTSD and addiction).**
- A group that includes adult males (not necessarily just for males). **(CCS referred consumers to support groups offered by NAMI Jefferson).**
- An emotion-regulation group for children/adolescents. **(CCS facilitated dialectical behavioral therapy skills based groups for adolescents at the Jefferson High School and Watertown High School).**
- A group on protective behaviors for children. **(CCS was unable to facilitate a group, however much work was done individually with the consumers by the service facilitator and therapists to increase children's protective behaviors).**
- A flyer to be sent out every three months for CCS consumers and supports. **(CCS was able to implement a newsletter quarterly to send to all consumers to include information about recovery, activities in the community and healthy recipes).**
- A fundraising event to raise money for the CCS program. **(The CCS program continued to discuss with the coordinating committee this idea and it was decided that in 2016 a fundraiser may be a good idea to assist with having a CCS summer picnic).**

The Regional (Jefferson, Rock and Walworth) CCS Coordinating Committee has been established and met four times in 2015. The coordinating committee was informed about what it means to be a shared service region (sharing services from the CCS service array by contracted providers between all three counties), as well as shared training opportunities for agency staff and shared contracted providers. They were informed about the trauma grant taking place across the counties. They were informed about how each county measures success of the program and how the region will be identifying quality improvement measures each year. Program data was reviewed between the region from 8/1/14 to 8/1/15 and the committee wants to focus on increasing employment, reducing the number of children involved in other systems, such as child protective services (CPS) and juvenile justice (JJ), decreasing the number of hospitalizations or the number of days in the hospital

and better understand what substances are being used/abused by consumers to see where to focus treatment/services. The committee would like to review the regional program data every six months.

CCS Jefferson, Rock & Walworth (JRW) Region

The CCS JRW Regional leadership met monthly to discuss providers being used, contracts to pursue, as well as developing a regional contract including sharing rates. This process was ongoing throughout the 2015 year with the help of the JRW regional fiscal team, directors and regional corporation counsel. By the end of the year the CCS JRW region sent out one joint contract for all regional providers for 2016 services.

During regional meetings, a list of trainings for 2016 was discussed and which county from the region will be responsible for organizing the training for agency staff and providers. The JRW region created a regional sign-in sheet and certificates for all trainings. The region utilized Jefferson County's tracking sheet for our quality improvement and tracking specific program markers. The regional tracking data was reviewed with the regional CCS Coordinating Committee, along with consumer satisfaction results. Based on these results it was decided by the region to focus on improving outcomes related to employment. The regional Coordinating Committee requested to review the regional tracking data for program markers every six months.

The region discussed the importance of having a shared site to store all necessary regional documents for all to have access. Rock County developed a drop box, however all counties in the region were not approved to utilize this. Rock County continued to take the lead on developing a more secure site for the region in hopes to have this up and running the first quarter of 2016.

Jefferson County facilitated training on May 20, 2015 for the region which included peer support providers, agency staff, potential contracted providers, contracted therapists and rehabilitation workers and foster parents. The training topics included: a better understanding of CCS, CCS work flow, CCS service array, mental health recovery (a peer support specialist from Jefferson County shared her story), trauma informed care, Medicaid documentation (time to practice and get feedback), cognitive behavioral therapy and meditation (practiced as a group), Coping Cat and aggression replacement training.

The JRW region was involved in the trauma informed care learning collaborative with the state. All counties sent agency staff and contracted providers to be participants of the Tier 1 training which focused on trauma focused cognitive behavioral therapy for children ages 3-17. Therapists provided this evidence based practice and the other staff within the agency that attended brought back the information to share with all teams. Jefferson County Tier 1 champions facilitated trauma informed care lunch and learns for agency staff, judges and drug court staff. The plan for 2016 is to continue the trauma informed care lunch and learns quarterly. The JRW region also participated in the Tier 2 training facilitated by a foster parent. Agency staff from child welfare and mental health programs participated along with biological parents, foster parents and caregivers of children involved in these programs that have been exposed to or experienced trauma. The focus of these trainings is to assist all present to learn about trauma informed parenting skills. Jefferson County staff participated in two eight week trainings. The Tier 2 champions from Jefferson County plan to facilitate the next eight week training in the fall of 2016. The JRW region is now in the planning phase of Tier 3 which is to train community providers in trauma informed care to better service children of our community who have been exposed to or experienced trauma. Jefferson County and Walworth County have chosen to focus training efforts on schools in 2016. Rock County chose the court system to train with this approach.

REVIEW OF 2015 GOALS

- Increase number of CCS providers for children/adolescents who are trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) by December 31, 2015. **The CCS team had three CCS service facilitators who were participating in the TF-CBT learning collaborative and servicing consumers with this evidenced based model between the ages of 5-17. One of the CCS service facilitators left the agency in July 2015. Two therapists from the JCHSD outpatient clinic have been utilizing this treatment model. CCS contracts with three clinics that have a total of eight therapists providing this service. CCS has been working on developing a contract with Orion Family Services who also have trained TF-CBT therapists. As a CCS region, Rock county and Walworth County also sent clinicians through this learning collaborative, thus contracts will be sought out in 2016 for these providers as well.**
- Decide on an assessment tool for children and adolescents to track at the time of admission and at the time of every recovery plan review. CCS will begin to implement this by May 1, 2015. **CCS started using the Patient Health Questionnaire for Adolescents beginning May 1, 2015.**
- Begin a group for children and/or adolescents using the Aggression Replacement Training (ART) model by June 2015. **CCS reached out to the Fort Atkinson High School requesting to partner with them and run a group for CCS consumers and their students three days per week. This was unable to take place in 2015. The CCS team will continue to consider providing this treatment in 2016 for JCHSD consumers.**
- Increase the number of peer specialists providing services to CCS children/adolescents and adults by December 31, 2015. **CCS contracted with Grassroots Empowerment for one peer support specialist in 2015. This peer support resigned and Grassroots Empowerment no longer wanted to contract for peer support services. CCS also contracted with NAMI Waukesha. NAMI hired two peer support specialists to provide services to CCS. During 2015, CCS used one of the two peer supports for services to adolescents and adults. One peer specialist who was employed with JCHSD resigned in 2015. CCS will continue to request from NAMI that more peer specialist be hired to work for our CCS program to better service the consumers of our community.**
- Ensure compliance in Medicaid billing requirements and documentation by reviewing notes every two weeks, discussing documentation weekly during clinical supervision, continuing collaborative documentation, training new staff in regards to proper documentation and weekly chart audits by December 31, 2015. **Due to the CCS expansion and additional staff that were hired in 2015, it was determined that additional staff were needed to assist with note monitoring and reviewing documentation requirements with co-workers. This system went into effect the last quarter of the year. CCS supervisor and Project YES Director continue to discuss billable time, note documentation and collaborative documentation during weekly supervision and team meetings. Newly hired staff members are monitored more closely for a longer period of time to ensure that they understand the Medicaid billing requirements regarding their documentation.**
- Present the annual report to the CCS coordinating Committee by October 31, 2015. **This was accomplished.**
- Complete at least one continuous quality improvement project using the NIATx model. **CCS completed a NIATX project with a focus on increasing the percentage of consumer outcomes met from 53.8% to 57% with a start date of 12/10/14 to 8/1/15 by introducing a new formatted progress note template. Outcome: 73.3% of objectives were met post new note format implemented. The sample size was 10 consumers for this time period. Beginning in the fall of 2015 CCS started another NIATX project to assist with increasing staff retention in the CCS program.**

- Continue to track outcomes for children and in 2015 use the data from 2013 and 2014 to establish services for 2016. ***For 2015, we developed an improved tracking system along with an internal procedure to ensure the data is collected properly. This has been a work in progress and CCS will continue to improve this tracking system in 2016. Each year we will be able to compare the data that has been collected to see where we are making progress and what we need to change in order to see progress. We will continue to track outcomes in these areas and we will continue to compare the outcomes from previous years to see where we need to implement or improve services.***
- Develop Project YES! services for youth and young adults ages 16-25 that are at risk of or have a mental illness and/or substance use disorder into the CCS service array to assist with a healthy transition into adulthood. **The Project Yes framework was created and implemented throughout 2015. A Project YES Director, as well as a transition service facilitator were hired in February 2015. Services were provided via the CCS service array and billed to medical assistance when applicable.**

PROGRAM GOALS FOR 2016

1. **Key Outcome Indicator: 72% of all treatment plan objectives are met**.
2. The CCS JRW Region will develop and implement a project based on data across the region and recommendations from the Regional Coordinating Committee.
3. The CCS JRW region will continue to develop contracts with providers who utilize evidenced based practices to serve the needs of the CCS program. Specifically the region will continue to increase the number of CCS providers for children/adolescents who are trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) by December 31, 2016.
4. Implement a DBT group for children and/or adolescents by November 1, 2016.
5. Implement a cooking group for youth/young adults by July 1, 2016.
6. Implement a Seeking Safety Group or DBT group for adults.
7. Increase the number of peer specialists providing services to all CCS consumers by December 31, 2016.
8. Ensure compliance in Medicaid billing requirements and documentation by reviewing notes every two weeks, discussing documentation weekly during clinical supervision, continuing collaborative documentation, training new staff in regards to proper documentation, and weekly chart audits.
9. Present the annual report to the CCS coordinating Committee by October 31, 2016.
10. Complete at least one continuous quality improvement project using the model by December 31, 2016.
11. Continue to track outcomes for all CCS consumers and compare data from previous years to establish services for 2016.

PROJECT YES! PROGRAM GOALS FOR 2016

These goals are stipulated by the State of WI collaborative team.

1. To expand the number of Y/YA aged 16-25 who receive age-appropriate, culturally competent, and evidence based behavioral health treatment and support within sub-recipient geographic areas.
2. To develop and implement local and state policies and practice changes that will improve Y/YA engagement, as well as promote successful transition into adulthood.
3. To increase awareness of providers, parents, youth and young adults on mental health issues and needs of Y/YA aged 16-25.
4. Create opportunities for positive youth development and youth leadership that engage and empower Y/YA aged 16-25.

REVIEW OF TRAINING GOALS FOR 2015

1. **Key Outcome Indicator:** Beginning in April of 2015, three CCS staff will participate in evidence based Trauma Focused Cognitive Behavioral Therapy training/learning collaborative focused on treating children ages 3-18. **This was accomplished. One CCS staff who participated in this training left the agency in July 2015. The remaining two CCS staff continue to utilize this model of treatment with their consumers and participate in bi-monthly supervision specific to this EBP.** These three staff will utilize the TF-CBT model of treatment when appropriate for specific consumers who have been exposed to or experienced trauma. This will be tracked by an increase in consumers engaging in treatment, and increasing the percentage of objectives met to 70%. **During this learning collaborative, each therapist used this model to treat 3-5 consumers. At the end of 2015, the CCS staff was completing the PRAC skills portion of the model with consumers. As mentioned above, CCS children met 77% of their objectives throughout 2015. This number includes the children receiving TF-CBT therapy. Six consumers were being treated for PTSD with the TF-CBT model. Of these six individuals, four were in the program long enough to have recovery plan reviews, one of which had two recovery plan reviews. Five reviews were completed and 73.2% of their objectives were met. Two of the TF-CBT consumers started the TF-CBT treatment at the end of 2015, thus there was no data collected for them.**

   Beginning in 2015, the CCS staff will apply their Motivational Interviewing skills and Cognitive Behavior therapy skills in all sessions. **CCS staff continues to utilize these two evidence based practices in their ongoing treatment with consumers. Four CCS staff became MI Coaches in 2015 and have been assisting with coaching CCS co-workers in improving their MI skills. In 2016, the MI coaches will be trained listening to staff MI tapes and scoring them.**
2. Implement DSM V by October 1, 2015. **All CCS staff have utilized the DSM V since October 1, 2015.**
3. All staff will be trained in using the new EMR (ECHO) by September 1, 2015. **CCS staff have been training on ECHO throughout 2015 and will continue to be trained in 2016 until CCS goes live with forms in Echo.**

TRAINING GOALS FOR 2016

1. **Key Outcome Indicator:** Throughout 2016 two CCS staff will continue to participate in evidence based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) training/learning collaborative focused on treating children ages 3-18. These two staff will utilize the TF-CBT model of treatment when appropriate for specific consumers who have been exposed to or experienced trauma. This will be tracked by an increase in consumers engaging in treatment, and increasing the percentage of objectives met specific to the TF-CBT consumers to 72%.
2. The CCS MI Coaches will be trained in scoring the MITI (Motivational Interviewing Treatment Integrity coding Tool) 4.2.1 and will begin utilizing this tool when reviewing staff MI tapes.
3. All CCS MI Coaches will provide team training up to four times in 2016 by utilizing activities from the MILLS (Motivational Interviewing Learning Labs).
4. Throughout 2016, the CCS staff will continue to apply their Motivational Interviewing (MI) skills and Cognitive Behavior therapy (CBT) skills in all sessions. Newly hired staff will be trained in MI Basics. All staff will submit MI tapes for scoring and set MI goals to increase proficiency.
5. A portion of the CCS team will continue to participate in the DBT consultation group for DBT training/supervision and will implement these skills in sessions and/or groups.

6. All staff will continue to be trained in using the new EMR (ECHO) as CCS works towards going live in this system.
7. The CCS JRW region will conduct trainings throughout the 2016 year for staff and providers.

PROJECT YES! TRAINING GOALS FOR 2016

1. Project YES! Staff will be trained in Transition to Independence (TIP) model, Wraparound, Stages of Development related to Y/YA, Motivational Interviewing or other evidence based practice offered by the State of WI Collaborative Team. These models will be implemented into sessions with Y/YA to determine effectiveness of this model, as well as use new practices to utilize when interacting with youth.
2. Project YES! Staff will develop a frame work on effective youth advocacy and leadership opportunities for Y/YA to enhance skills in order to increase youth voice at a local level.
3. Project YES! Staff will continue to learn effective Outreach when interacting with Y/YA, parents, community members, community partners, etc., to increase awareness of mental health challenges among Y/YA and to connect with unserved/underserved youth and young adults in need of support.

EMERGENCY MENTAL HEALTH

Our Emergency Mental Health (EMH) crisis intervention services were certified under HS 34 in October of 2007. In becoming certified, the Department did not have to add any new services or new staff. The Department organized procedures, formalized policies, developed billing systems and trained staff across the entire agency. We continue to revise and update these policies and procedures. Human Services Crisis staff, who are certified intake workers, complete all emergency detentions for the county.

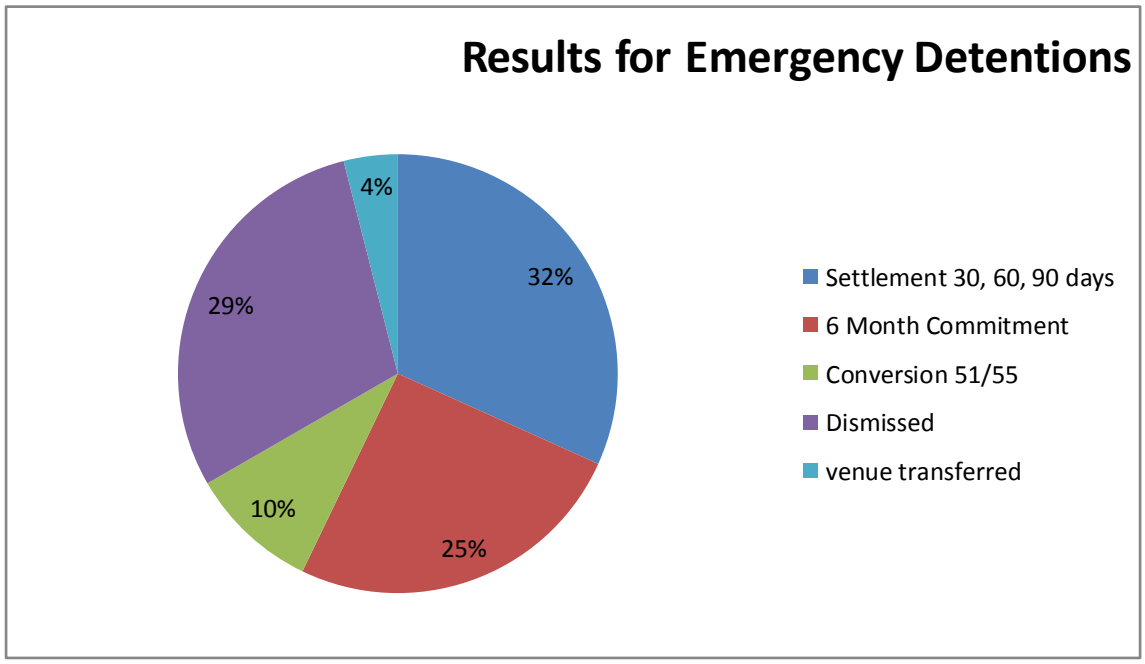
Intake/Crisis staff operate 24/7 on site, including weekends and holidays. Potential Emergency Detentions are assessed by County staff using an immediate response system in consultation with the Medical Director. Depending upon acuity of presenting issues, including safety, determinations are made for immediate intervention including inpatient hospitalization, group home or other crisis stabilization placement. St. Mary's and UW in Madison, Aurora in Wauwatosa, and St. Agnes and Fond du Lac Health Care Center in Fond du Lac are the primary facilities used for Emergency Detentions for adults. Aurora in Wauwatosa, St. Elizabeth's in Appleton, and Wheaton Franciscan in Racine are the primary facilities used for Emergency Detentions for children/adolescents. Winnebago Mental Health Institute is used as our last option for an emergency detention. Non-crisis community requests or referrals for services are also managed by Crisis staff, which assess immediate and longer term needs with consumers, and then connect them to the needed services by written and oral discussion with the appropriate supervisor and staff. The Crisis staff has immediate and open access to the Medical Director as well as to supervisors as needed.

CONSUMER SATISFACTION

The EMH program conducted a crisis services satisfaction survey to measure the consumer satisfaction of our program. We had 12 adult respondents this year. Below is a chart which breaks down by question how satisfied respondents were with the services that were provided and how they were provided. As a result of this survey items that will be worked on are explaining to people their options in a way they can understand and making sure that they feel they are being heard and that their concerns are considered. By doing these two things more people will feel that the experience was helpful in getting the services/supports that are needed.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The situation was handled promptly	**8.3%**	**8.3%**	**0%**	**50%**	**33.3%**
The staff were respectful and professional	**0%**	**8.3%**	**8.3%**	**41.6%**	**41.6%**
The options were explained to me in a way I could understand	**0%**	**16.6%**	**16.6%**	**41.6%**	**25%**
Even if I did not agree with the outcome, my concerns were considered	**8.3%**	**8.3%**	**8.3%**	**41.6%**	**33.3%**
The experience was helpful in getting necessary services/supports	**8.3%**	**8.3%**	**16.6%**	**50%**	**16.6%**

In 2015 we had 8,677 EMH/Suicide contacts. These people received crisis assessments, response planning, linkage and follow up, and/or crisis stabilization services. Of these contacts 421 emergency detention assessments were completed, 126 people were emergently detained, with 10 of those being detained in another county and venue transferred to us. Of the individuals who were emergently detained, 22 of them were out of county residents, 13 individuals were placed in a group home, 3 people were emergently detained from the Jefferson County Jail, and only 27 people were currently receiving services through our human services department.



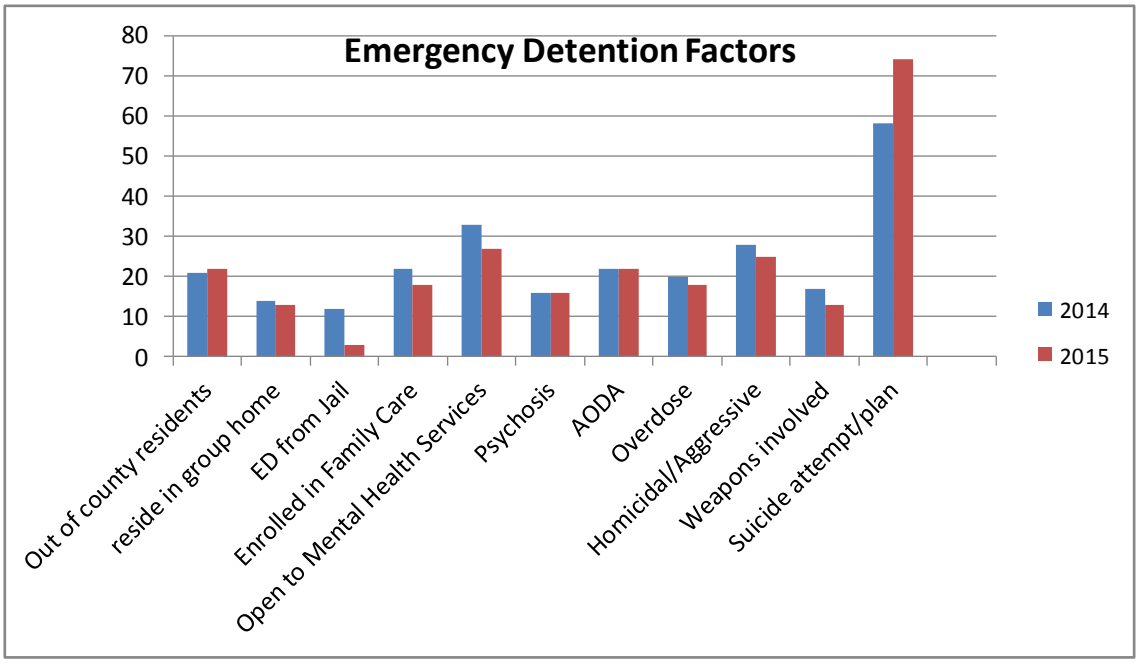
KEY OUTCOME INDICATOR

Our key outcome indicator, a measure of how we are doing our work, is our diversion rate, i.e. the number of times we are able to find a disposition that is not an emergency detention. We adhere to the statute of least restrictive setting for each person and we want each person to have the best possible outcome. To do this, we consider a number of factors: we complete a standardized suicide assessment, we consider lethality, means, opportunity, age, gender, access, and past history. When possible, we divert the person to a setting that is not locked facility. In 2015 all crisis staff completed the counseling on lethal means webinar. We also implemented using the Columbia Suicide Risk Assessment as our standardized tool for suicide assessment.

The key outcome indicator for 2015 was to maintain the diversion rate of 2014. The table below shows the comparison between the years for emergency detentions, diversions, percent diverted and percent emergently detained. In 2015 there were 126 emergency detentions with 10 of them originating in other counties and venue transferred to Jefferson County. Those 10 were removed as we did not have any opportunity to assess and make decisions regarding the emergency detention of those individuals.

Year	2014	2015
Total # Assessments	319	421
Total # Emergency Detentions	142	116
Total # Diversions	177	305
Percentage of Diversions	55.4%	72%
Percentage of Emergency Detentions	44.5%	28%

We track and review factors regarding people that were placed under an emergency detention. These include if they were in services, residents of another county, in family care, and/or placed in group homes. The chart below shows the comparison from 2014 to 2015. There is a noted decrease in the emergency detentions from jail and an increase in the amount of people who attempted or had a plan for suicide.



The Lueder house, our crisis stabilization facility, is an 8 bed class A CBRF (community based residential facility). In 2015, there were 145 admissions at the Lueder house. The average length of stay for consumers was 13 days. Seventy-five individuals were served by the Lueder House. Several were admitted more than once for non-crisis stabilization services. We were also able to bill $450,805.90 to Medicaid for our crisis stabilization services and received payment of $114,468.79.

In the seventh full year of certified Emergency Mental Health services, we billed $179,976.30 to Medicaid for our services and received payment of $91,639.58. We billed $16,969.00 to private Insurance and received payment of $1,150.75. We also billed $113,497.79 to private pay individuals and received payments of $3,847.30. Lastly, we billed Family Care $3,720.00 and received payment of $919.12.

Youth Crisis Services

In 2015 we recognized the need to find more options for youth is crisis. We assembled an internal team and identified a number of interventions that were needed. The internal team consisted of all the Behavioral Health Supervisors, the Director, the Child and Family Manager, and the Child and Family Supervisors.

In 2015 we were able to obtain new hospital contracts in order to have more options for both voluntary and involuntary hospitalizations. We plan to add two more contracts with hospitals for 2016. We were able to identify and train a local foster home for crisis stabilization services for youth. We also trained Orion in home safety staff in Emergency Mental Health to provide in home crisis stabilization for youth. These options allowed for crisis staff to assess the youth and decide whether in home stabilization supports with a safety plan would benefit the youth and their family. A crisis plan is written that would explain the current situation, the safety plan, and the expectation of services that the in home stabilization provider would provide. In 2015 we developed Integrated Crisis Plans for youth and their families. These plans focus on the needs and resources of the youth and the entire family in time of crisis. In 2016 these plans will be fully implemented agency wide.

In 2013, there were 33 youth detained, in 2014 there were 18, and in 2015 there were 17 youth detained. Supervisors, Managers, and our Director continue to meet monthly as a team to review data, identify needs, and continue quality improvement.

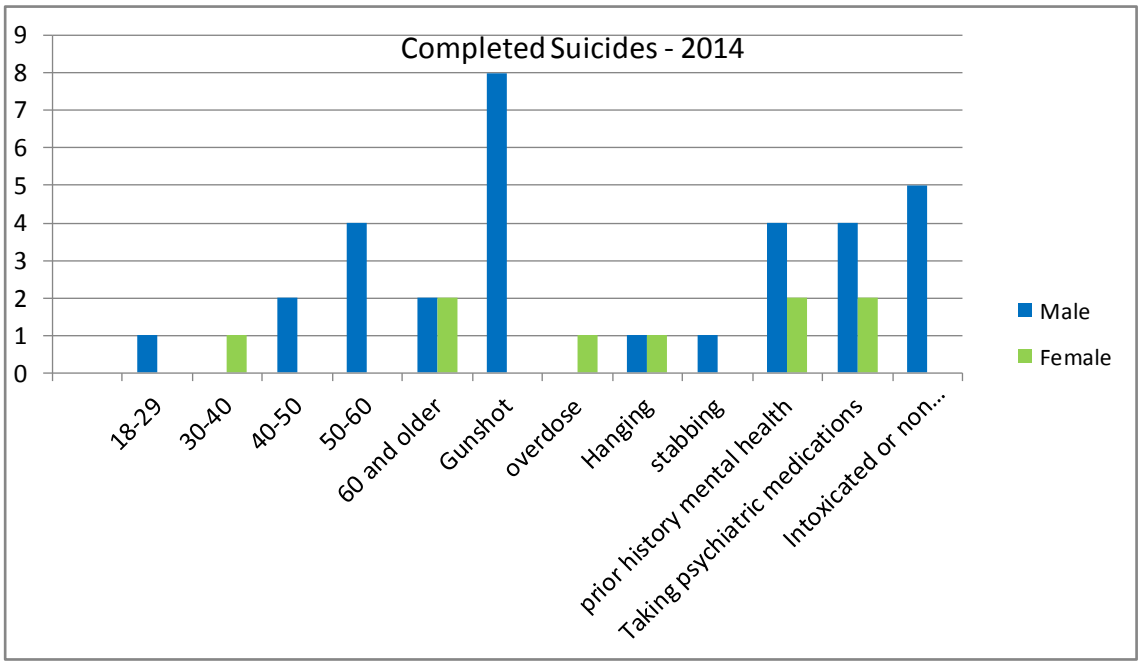
Zero Suicide

According to the Action Alliance of Suicide Prevention, Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

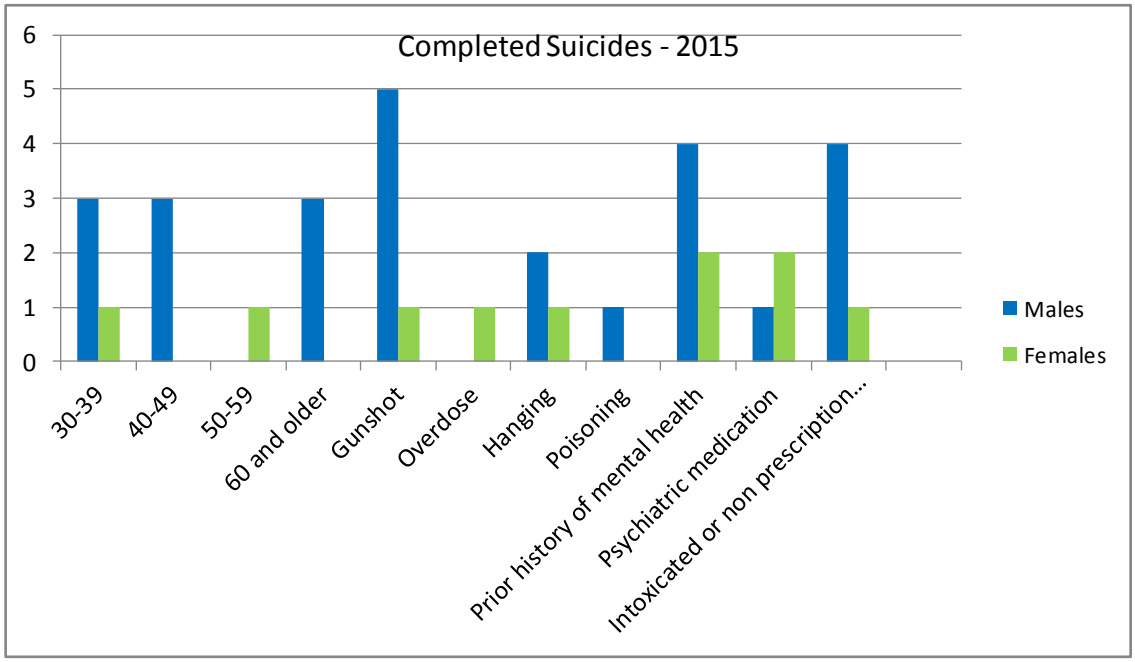
In April of 2015 a team of people from Jefferson County Human Services attended the Zero Suicide Academy. The team consisted of representatives from the behavioral health unit, health department, and consumers. We officially kicked off our Zero Suicide project on June 1, 2015 by placing a flyer explaining what Zero Suicide is and a Zero Suicide cookie on the desk of each staff person. The team developed a PowerPoint that played on the lobby TV to create more awareness for consumers and other community members.

An organizational study was completed and we looked at the changes we wanted to make in 2015 to begin to achieve our goal of Zero Suicide. We trained staff on "Counseling of Lethal Means and Lethal Means Restriction." We began using the Columbia Suicide Risk assessment across the agency and introduced it to Law Enforcement. In conjunction with a project that the crisis team was doing we worked on seeing people prior to being discharged from the hospital to go over discharge recommendations, needs once discharged, appointments with providers and what follow up would look like from the crisis team. Throughout 2015 we continued to create awareness by expanding our team to include a champion from each team within the department.
We also felt it was important to review the completed suicides in Jefferson County. Charts on the following page are from 2014 and 2015 to show the number of completed suicides for each year and some demographics in order to show any types of trends.

In 2014 the age range was from 24 years old to 91 years old. One person was receiving mental health services from Jefferson County Human Services.



In 2015 the age range was from 30-72 years old and only one of the individuals was receiving mental health services from Jefferson County Human Services.



REVIEW OF GOALS FOR 2015

1. **<u>Key outcome indicator</u>: maintain current emergency detention diversion percentage, whenever possible, by continuing to review and improve voluntary options.**
   We were able to improve our diversion rate in 2015 to 72% thus accomplishing this goal.
2. **Implement and go live with the ECHO electronic health records system by September 1, 2015.**
   We did not go live for EMH in 2015. EMH does have an electronic records system that MIS created and we are currently using this until going live with ECHO.
3. **Apply to the Zero Suicide Academy by March 6, 2015. If accepted the team will attend the academy in April and then spend the year implementing the project.**
   We accomplished this goal and were able to attend the academy and start implementing changes.
4. **Complete a project involving the behavioral health division. This project will focus on follow up with persons when they are discharged from a hospital. This will be completed by September 1, 2015. This will facilitate us reviewing and reducing our readmission rate.**
   We completed this project and are continuing to track data in regards to reducing readmission rates to the hospital. We completed several cycles for this projecting adapting, adopting, and discarding things that did not work. We revised our discharge form that is completed with the person prior to admission 4 times; we also changed peoples roles within the discharge process until we found what worked best. Currently we have one crisis worker who does all the contact with the hospital upon someone's admission and then that same worker goes to see the person prior to discharge to discuss discharge recommendations, follow up appointments, and if they have needs such as groceries, transportation to appointments, etc. when they return home.
5. **Implement the Columbia Suicide Assessment and the Columbia Risk assessment tools by July 1, 2015.**
   We have implemented this not only with crisis but agency wide. This tool gives us a way to all speak the same language. Across the agency we are asking the same questions when assessing someone's risk for suicide.
6. **Implement the use of crisis stabilization criteria form. Dr. Haggart will fill this out each time he meets with consumers at the Lueder House to ensure they still meet stabilization criteria. If they do not they will be put on placement status and subject to a daily charge for staying at the Lueder House. This will be implemented by April 30, 2015.**
   This goal was achieved. Dr. Haggart is filling out this form when seeing consumers at the Lueder House and the completed form is put in their file.
7. **Continue to develop further stabilization options for adult and children.**
   We now have a contract with Rock County to use their stabilization home, Harper's Place. We utilized Harper's Place 3 times in 2015 and continue to utilize Bayside Place in Madison as another stabilization option. As mentioned in the report above, we have a foster home trained for stabilization of youth, and we have trained Orion in home safety team to provide in home crisis stabilization.
8. **Develop further contracts with hospitals to be providers when an emergency detention is necessary.**
   We were able to develop contracts with Aurora Hospital for adults and children/adolescents for voluntary and involuntary hospitalizations. We also have a contract with Columbia St. Mary's. We started working on contracts with St. Elizabeth, Community Memorial, and Swedish American in 2015 but haven't concluded these yet.

EMH Training Goals for 2015

- **Train EMH staff in the Columbia suicide rating scale and the Columbia suicide risk assessment.**
    - Not only were EMH staff trained but staff and contracted providers across the agency.
- **Attend the Zero Suicide academy.**
    - We attended the Zero Suicide Academy in April**.**
- **Train in-home and foster homes to provide crisis stabilization for children.**
    - We trained a foster home and in home providers for stabilization services in 2015.

Goals for 2016

1. **Key outcome indicator: maintain current emergency detention diversion percentage, whenever possible, by continuing to review and improve voluntary options.**
2. **Complete a project in collaboration with Winnebago Mental Health Institute and Washington County.**
3. **Reduce the number of admissions to Winnebago Mental Health Institute from 2015.**
4. **Complete a project involving the new integrated crisis plan to see if it reduces out home placements and hospitalizations for children and adolescents.**
5. **Complete a project for the Lueder House.**
6. **Collaborate with Watertown PD in developing a rapid entry protocol for people addicted to heroin.**
7. **Complete 3 Mental Health First Aid trainings. One of the youth trainings will involve training a school district.**
8. **Provide training for Law Enforcement on the Columbia Suicide Risk Assessment by May 1, 2016.**
9. **By September 1, 2016 the Zero Suicide team will identify key partners within the community to start forming a Suicide Prevention Coalition in Jefferson County.**
10. **The Zero Suicide team will continue to analyze the data surrounding completed suicides to determine what type of outreach or training would be instrumental in reducing the number of completed suicides.**

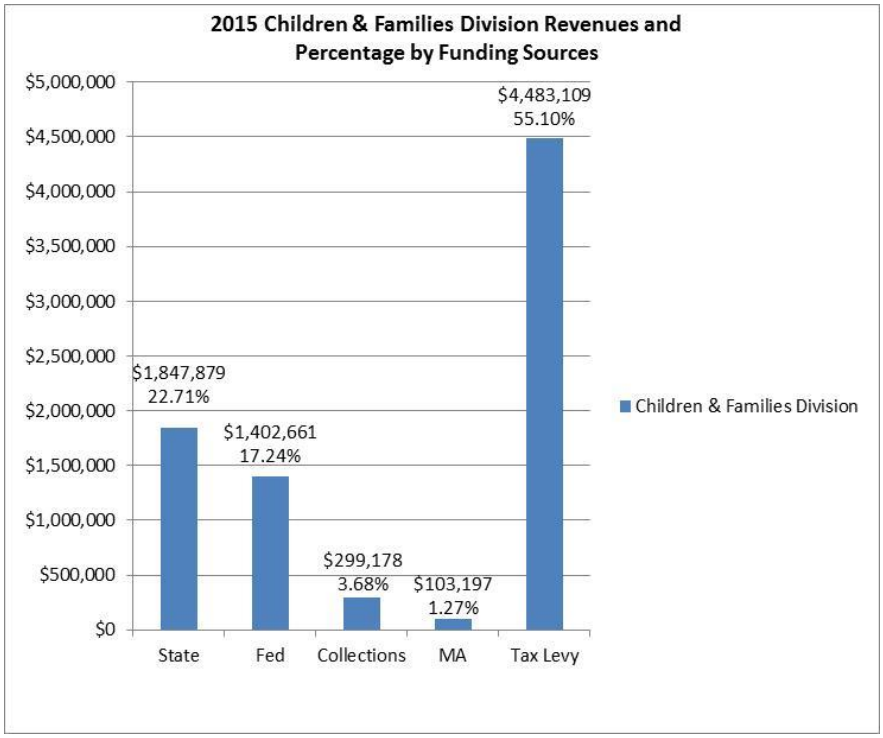
CHILD & FAMILY DIVISION

"Keeping families together and assisting them to live in their own communities"

The Child and Family Division of Jefferson County Human Services is designed to provide interventions and services from birth to adulthood. These treatment based services and interventions come in a variety of forms provided by the following teams; Juvenile Court Intake, Access, Initial Assessment, Birth to Three, the Busy Bee Pre-school, Child Protective Services, Juvenile Justice, Coordinated Service Teams, Children's Long Term Support, Child Alternate Care, and Independent Living. These diverse teams that make up our Child and Family Division serve the residents of Jefferson County through a variety of multi-faceted programs. The long term goal across the division is to partner with the family to develop a comprehensive client centered treatment plan that provides coaching and service provision for long term independent success. The primary focus of this division is to provide safety, permanence, and well-being across the continuum from birth to the age of majority.

A core belief of our Division is that children have the right to live in a safe environment and, if needed, with appropriate intervention and services to assist them until our interventions are no longer needed. In 2015 the Child and Family Division continued efforts aimed at families with complex alcohol and drug issues along with severe mental health needs. One effort to confront these issues was the use of community therapist office time at JCHSD. Another measure taken to deal with these complex multifaceted issues was to continue the tradition of participating in the variety of opportunities provided by DCF and DHS. Through the successful application and awarding process, the division continued the long tradition of successful partnerships with the state in the form of the Post Reunification Services Program, Family Find Initiative, Citizen Review Panel, Social Emotional Competencies roll out, Pyramid Model, Trauma Informed Care initiative and one of our staff members was awarded the 2015 Secretary's Caring For Kids Award from the Secretary of Children and Families at DCF.

The Child and Family Division revenue comes from County tax levy, State and Federal funds as denoted in the following graph. The most significant expenses for the Division are customarily alternate cares costs, staff wages and benefits.



Depreciation
County Indirect Cost

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers (County levy).

For 2015 the Division established overarching goals for the Division as well as key outcome indicators for each team. The overarching goals for the Division are as follows:

- Safety, permanence, and well-being for all children referred to the Department
- Develop prevention and treatment programs for the emerging issues impacting children and families

The key outcome indicators include meeting state and federal indicators, timelines, key staffing procedures, hospitalization prevention, team composition, community placement preservation, and secondary education attendance.

The Division continues to provide best practice and evidenced based practices across all teams to build on the pre-existing strengths, while addressing the needs of children and families. The staff of the
Child & Family Division is dedicated to the community, their colleagues, the agency and most of all to the children of Jefferson County.

CHILD & FAMILY DIVISION TEAMS

Access and Initial Assessment

Juvenile Court Intake

Child in Need of Protective Services

Juvenile Justice Integrated Services

Restorative Justice Programs

Coordinated Service Team

Birth to Three

Busy Bees Preschool

Child Alternate Care

Children's Long Term Support Waiver Program

Independent Living

Incredible Years

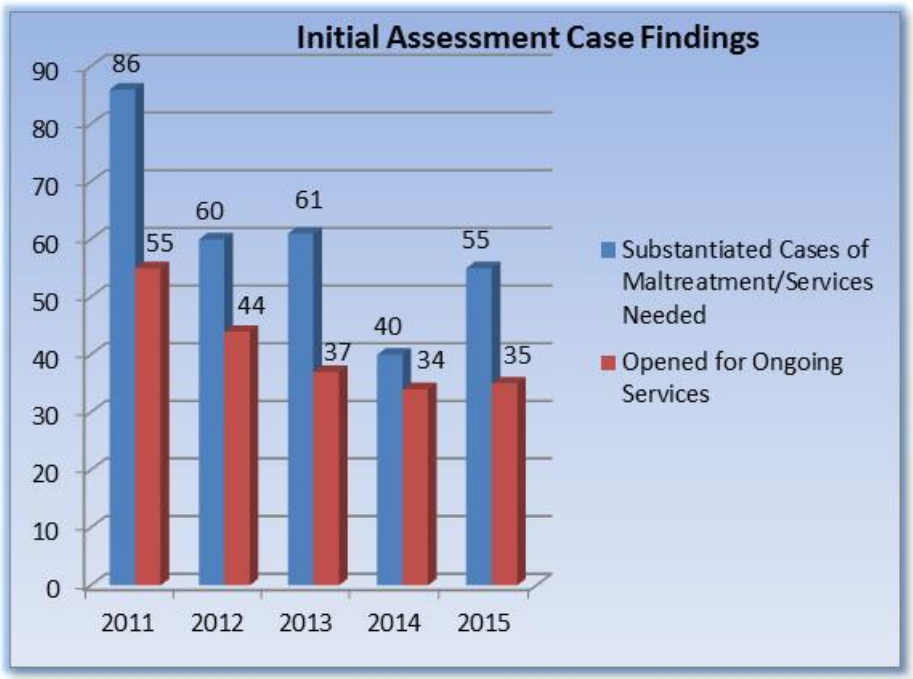
Intake

"Our mission is to collaborate with families in order to meet their needs, while ensuring the safety of our children, youth and community as a whole"

The Intake Unit continues to be the access point for interventions and services for children, youth, and families in Jefferson County. These interventions and services include receiving and screening access reports regarding child welfare and juvenile justice, conducting Child Welfare Assessments, conducting Child Protective Services Initial Assessments, as well as processing Truancy and Juvenile Justice Referrals. Our overarching goal is to collaborate with families in order to meet their needs, all while ensuring the safety of our children, youth, and the community as a whole. Since 2012, the Intake Unit has been a part of many initiatives, including Alternative Response, In-Home Safety Services, Family Find and Engagement, Team Based Practice, Motivational Interviewing, and as of 2015, we became part of the Agency-Wide Trauma Informed Care initiative. Being part of these initiatives has not only enhanced and refined our skillset, but we have also been able to gather data in certain areas to demonstrate the value and impact these initiatives have had in our work with families.

As noted above, the Intake Unit is responsible for conducting Initial Assessments regarding allegations of child maltreatment. Prior to December 2012 our Agency was only able to conduct traditional Initial Assessments, but since that time we have become an Alternative Response county. The purpose of CPS intervention has always been to ensure child safety while partnering with families to meet their needs, but unlike a traditional Initial Assessment, the Alternative Response approach focuses on engagement, teaming, and connecting families with both formal and informal services up front. While traditional Initial Assessments are warranted in high-risk child abuse and neglect cases, research has shown that Alternative Response is a more appropriate and successful practice in low to moderate-risk child abuse and neglect cases. We have found great value in working with families under the Alternative Response approach as our working relationships with families are more trusting and less adversarial, and it appears to have a direct impact on the amount of cases opened for ongoing services within our Agency.

Per the Initial Assessment Case Findings graph at right, the number of Initial Assessments we have completed as substantiated/services needed and opened for ongoing services have steadily declined over the past five years. This is noteworthy as the number of Initial Assessments conducted each year has essentially remained the same since 2011. This data would suggest that having trusting and non-adversarial relationships with families has led to their willingness to be more open with information and be more cooperative with the Initial Assessment process, which in turn leads to better information



gathering and assessment by staff. In 2015 Jefferson County was recognized as the county in Wisconsin with the highest percentage of Alternative Response cases conducted with our average being 66%, while the state average was 37% in 2015.

Jefferson County has been working with Rock and Green Counties under a consortium since 2012 after being awarded an In-Home Safety Services Initiative Grant by the Department of Children and Families. Under this consortium we team with Orion Family Services, Inc. to create and implement in-home safety plans that control danger threats, thereby keeping children safely in their homes. Components of the In-Home Safety Services Initiative continue to include concentrated safety monitoring through home visits and phone calls, a 24/7 crisis response hotline, volunteers and informal supports to families, and connection to resources. As with Alternative Response, we have also seen the value of In-Home Safety Services and we are committed to maintaining children in their homes whenever possible. Not only, and most importantly, are families more likely to be successful when children are maintained in their homes, but data has also shown the significant savings this has had on alternate care costs. In 2013, Jefferson County referred seven families for In-Home Safety Services in which out-of-home placements for 15 children were prevented and over $96,000 was saved in alternate care costs. In 2014, we referred nine families for in-home safety services in which out-of-home placements for 16 children were prevented and $81,000 was saved in alternate care costs. In 2015, we referred nine families for In-Home Safety Services in which out-of-home placements for 12 children were prevented and $55,000 was saved in alternate care costs. Jefferson County has saved over $230,000 during our three year involvement in the In-Home Safety Serviecs program allowing 43 children to remain in their biologocal home. The Alternative Response approach has seemingly aided in the success we have experienced with the In-Home Safety Services initiative as forging these trusting and non-adversarial relationships with families allows for better safety assessment and In-Home Safety planning.

Along with Alternative Response and In-Home Safety Services, we also continue to use the methods and strategies of Family Find and Engagement, as well as Team Based Practice. When there is no other option but to place children and youth outside of their homes due to safety concerns our goal is to preserve relationships and place children and youth with relatives or other natural family supports. The Family Find and Engagement model offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. These tools and strategies are not only successful with out-of-home cases, but are also valuable when working with intact families as well. Two of the specific tools that are frequently used are Mobility Mapping and Connectedness Mapping – both of which are directly done with families with the goal of identifying who families consider to be their supports. As with Family Find and Engagement, Team Based Practice also empowers families to identify and utilize their own natural supports as it is a process by which families work with staff to form teams that focus on achieving safety, permanence, and lasting change for families. Outcomes from using both these models include increased reunification rates, improved wellbeing and placement stability, decreased out-of-home placements, and a strong sense of connectedness for children.

Regardless of the circumstances in which we are working with children, youth, and families, we strive to use Motivational Interviewing and keep Trauma Informed Care at the forefront of our daily practice as both are fundamental and embrace the spirit of our work with consumers. We continue to build upon our skillsets and infrastructure in both these areas with the goal of effecting positive change and approaching our work through a trauma-informed lens.

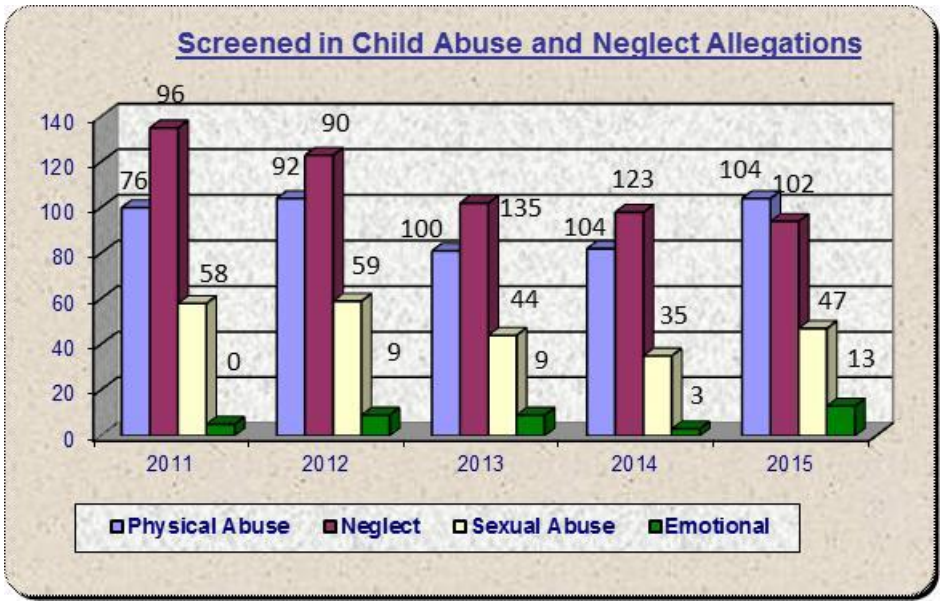
There is an MI (Motivational Interviewing) Implementation Team within the Agency that two staff members from the Intake Unit are part of. This Team not only focuses on reinforcing our knowledge and application of the tools and skills we have learned, but it also focuses on building our internal infrastructure and culture around the use of MI. The MI Implementation Team recruits internal staff to be MI Coaches and facilitates MI activities on an agency-wide level. The same two Intake Unit staff members that are on the Implementation Team are also MI Coaches. The MI Coaches receive advanced training on an ongoing basis so they in turn can

provide training to other staff through transfer of learning activities, learning labs, and other educational opportunities as sponsored by the Implementation Team.

In the spring of 2015 our Agency also became part of the Wisconsin Trauma Project which was comprised of a three tier training component. While staff across the agency received initial training, particular staff members were selected to be part of the tiers, which included one of the Intake Unit staff who was on Tier 1. Tier 1 was designed for mental health clinicians as well as identified staff whose role was to bring the valuable information back to the agency to assist with the transition to a trauma informed system. Tier 2 was designed to teach caregivers how to recognize and respond to trauma in the home environment. And Tier 3 involved ongoing effort by way of system wide training, consultation, technical support and coordination to create a trauma-informed and responsive system of care. Those selected to be on a Tier received more comprehensive and ongoing training, and in turn, were charged with sharing this knowledge with their colleagues in efforts to transition our Agency to a trauma informed system. The staff who participated in the three tiers provide transfer of learning to their colleagues during team meetings and in other settings, such as ongoing Lunch & Learn events.

REVIEW OF CPS AND JUVENILE JUSTICE DATA:

Our overarching goal is to collaborate with families in order to meet their needs, all while ensuring the safety of our children, youth, and the community as a whole. As reflected on the graph, 258 allegations of child maltreatment were screened in for Initial Assessment in 2015 and only 5 % of the cases required removal of children from their homes due to maltreatment or safety threats that couldn't be sufficiently controlled within the home. The majority of these resulted in safe placements with natural family supports, such as relatives, neighbors, and family friends. Likewise, in the 268 juvenile referrals processed in 2015, only 4% required removal of juveniles from their homes due to victim or community safety concerns that couldn't be adequately controlled within the home environment. This data is promising and it will continue to be evaluated as it's anticipated that the tools and skills acquired through all of our initiatives have a direct impact on alternate care placements for children and juveniles.



As illustrated on the graph at right, the number of allegations screened in for Initial Assessment since 2011 has fluctuated year to year by about 15%. Overall, the five year trend shows that allegations of neglect were the most investigated type of child maltreatment in Jefferson County but allegations of physical abuse were the most investigated type of maltreatment in 2015. When maltreatment of a child has occurred or a safety threat to a child has been identified during the Initial Assessment process, it is likely that the family will be referred for ongoing services within our Agency. Such ongoing services can be in the form of a six-month Informal Disposition Agreement in which the family agrees to receive services on a voluntary level, or a formal CHIPS Court Order in which the family is ordered by the Juvenile Court to receive services through our Agency. It should be noted that a case can involve more than one child within the family.

As illustrated on the graph below, there were 86 substantiated cases of maltreatment in 2011 with 55 of those being opened for ongoing services within our Agency. In 2012, there were 60 substantiated cases of maltreatment with 44 of those cases being opened for ongoing services. With the Alternative Response approach being utilized in 2013, 61 cases were identified as Substantiated or Services Needed with 37 of those being referred for ongoing services within our Agency. In 2014, 40 cases were identified as Substantiated or Services Needed with 34 of them being open for ongoing services within our Agency. And in 2015, there were 55 cases identified as Substantiated or Services Needed with 35 of them being open for ongoing services within our Agency. This data shows that cases open for ongoing services within our Agency have steadily decreased in the past five years. This is noteworthy and suggests that the way the Initial Assessment Workers are using Alternative Response, In-Home Safety Services, Motivational Interviewing, and Trauma-Informed Care is helping us better engage families, identify their needs quicker, utilize natural supports, and "frontload" services in order to circumvent the need for ongoing CPS involvement for some families.

The Intake Unit is also responsible for processing Juvenile Justice and Truancy Referrals. These referrals are generated by local law enforcement and schools. Processing these referrals generally includes meeting with the juvenile and family at which time the referral is discussed at length, social information on the juvenile and family is gathered, case disposition is discussed, and the Juvenile Delinquency Risk Assessment is completed. As of 2015, both the Intake Unit and the Ongoing Juvenile Justice Team utilize the assessment tools provided through COMPAS, which is an integrated web-based program that incorporates evidence-based practices, including Trauma Informed Care and Motivational Interviewing. The assessment tools the Juvenile Court Intake Workers use in particular aid them in determining a juvenile's risk to reoffend, as well as what services and interventions would most likely benefit each juvenile. The Juvenile Court Intake Workers then forward these cases onto the District Attorney's Office with their recommendations for how each case should be addressed. Such recommendations can include dismissal of a case, filing of a Deferred Prosecution Agreement or Consent Decree, or filing of a Delinquency Petition which initiates formal court action. The Juvenile Court Intake Workers continue to be very thoughtful in determining disposition of each referral they process and strive to not only take a restorative justice approach, but also maintain juveniles safely in their homes and communities when possible.

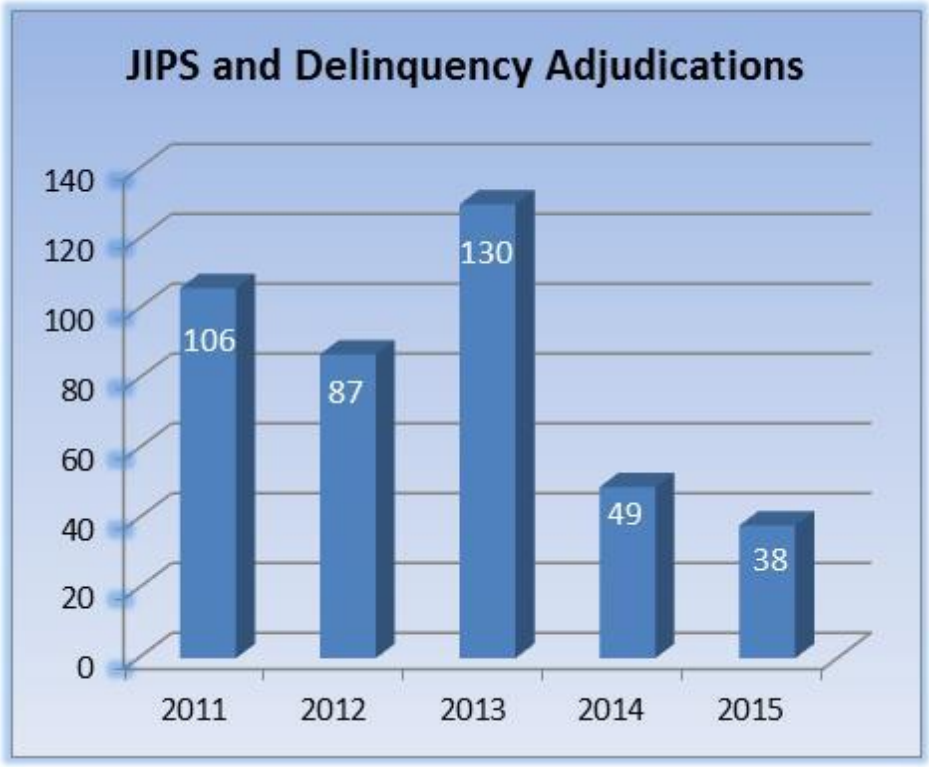
As illustrated in the graph below, the number of juvenile offenses referred by Law Enforcement decreased between 2011 and 2015 by 21%. Anecdotal data would suggest that the steady decrease in referrals over the past five years is because the Juvenile Court Intake Workers are using tools such as Motivational Interviewing, COMPAS, and Trauma-Informed Care to help better engage youth and families and identify their strengths and needs quicker in order to tailor individualized recommendations. Our focus is restorative justice and we feel that we are able to accomplish this in many cases through Deferred Prosecution Agreements and Consent Decrees rather than through formal court intervention. From the 268 referrals processed in 2015 only 47 of them were prosecuted in Juvenile Court proceedings via Consent Decrees or formal JIPS and Delinquency Court Orders.

The following graphs summarize type of referrals, number of referrals for each youth, age of youth, and number of adjudications.

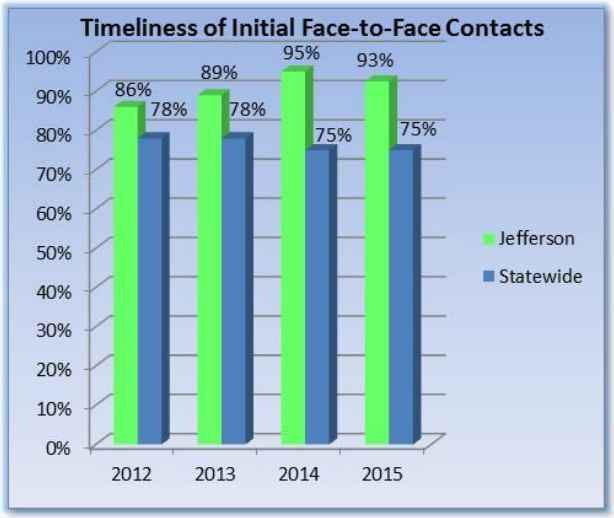
POLICE REFERRALS for JUVENILE OFFENSES 1 and 5 Year Comparisons						
OFFENSES (2010-2014)	2015	2014	1 Year (2014-2015) Increase/Decrease	2015	2011	5 Years (2011-2015) Increase/Decrease
Alcohol/Tobacco	5	2	3	5	2	3
Arson	5	1	4	5	0	5
Battery	40	40	0	40	31	9
BurglaryRobbery	17	7	10	17	43	(26)
Burning Materials/Fireworks/Explosives	1	0	1	1	0	1
Contempt of Court/Violation of Court Orders	0	5	(5)	0	0	0
Crimes Against Children/Other	4	3	1	4	12	(8)
Criminal Damage to Property	23	30	(7)	23	36	(13)
Criminal Trespass	6	5	1	6	6	0
Disorderly Conduct	104	124	(20)	104	136	(32)
Drug Related	40	35	5	40	44	(4)
Fleeing/Escape	0	2	(2)	0	0	0
Forgery	0	0	0	0	2	(2)
Intimidation/Harrassment	0	0	0	0	2	(2)
Obstructing/Resisting Arrest	16	17	(1)	16	12	4
OWVWOC/Other Vehicle	3	5	(2)	3	5	(2)
Receiving Stolen Property	3	2	1	3	2	1
Reckless Endangerment	2	3	(1)	2	2	0
Sex Offense	27	25	2	27	42	(15)
Theft	41	45	(4)	41	58	(17)
Truancy	32	30	2	32	31	1
Weapon Related	13	12	1	13	12	1
TOTALS	382	393	(11)	382	478	(96)

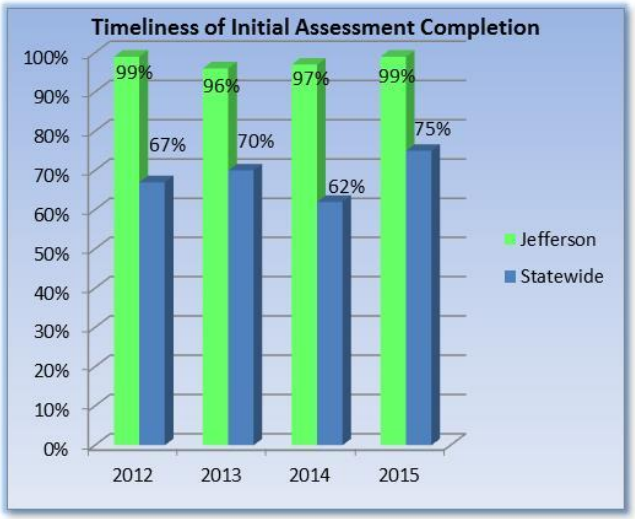
2015 Multiple Juvenile Referrals by Age									
		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Juveniles Referred	% of Total
Referrals	1	15	17	26	14	10	2	84	52%
	2-3	5	4	13	9	13	0	44	27%
	4-5	2	3	0	6	11	0	22	14%
	6-8	0	1	4	3	1	0	9	5%
	9+	0	0	2	1	0	0	3	2%
Total Juveniles with Multiple Referrals per Age		22	25	45	33	35	2	162	100%

2011-2015 Juvenile Intake Referrals by Age							
	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Youth
2015	22	25	45	33	35	2	162
2014	20	22	62	24	32	8	168
2013	19	28	74	43	43	2	209
2012	11	33	62	39	38	4	187
2011	14	45	70	56	49	5	239



Not only does the Intake Unit take great pride in working with families to meet their needs, we also take great pride in maintaining compliance with State and Federal Standards and timelines. As illustrated in the graphs below, in 2015, Jefferson County's performance scorecard for completing Initial Assessments within the mandated 60 day timeline was 99%, whereas the State average was 66%. The Intake Unit's performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 93%, whereas the State average was 75%. Data compiled internally indicates that 100% of Juvenile and Truancy Referrals were processed accordingly within the mandated 40 day timeline in 2015.





Review of 2015 Goals:

1. **The Key Outcome Indicator for 2015 was to meet 100% of mandated timelines.** This goal was accomplished. *According to DCF reporting, the Intake Unit completed 218 Initial Assessments in 2015. Our performance scorecard for completing Initial Assessments within the mandated 60 day timeline was 99.25%, whereas the State average was 66.86%. The Intake unit's performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 92.45%, whereas the State average was 82.03%. Data compiled internally indicates that 100% of Juvenile and Truancy Referrals were processed accordingly within the mandated 40 day timeline.*

2. Continue to build upon what we have learned through our training initiatives in Motivational Interviewing, Alternative Response, Family Find, and Team Based Practice. This will be accomplished through implementation of the tools and skills in our daily practice, as well as by incorporating the concepts and language in our documentation and reports. ***This goal was accomplished****. The culture and expectation of the Intake Unit is one in which we are always using and refining our skillset - not only because we take pride in doing so, but also because we have seen positive outcomes as a result. In 2015 the Intake Unit accomplished this by focusing on the use of a specific tool and skill in different intervals and then reporting back on everyone's successes and challenges. This not only helped enhance proficiency, but it also created open dialogue and transfer of learning opportunities. And as our proficiency has increased, so has our ability to reflect this in our documentation and reports because we our inherently gathering and assessing information better and more comprehensively when working with children, youth, and families.*

3. Restructure the Juvenile Court Intake form used when processing juvenile referrals so that it incorporates the tools and skills acquired through Motivational Interviewing as this will allow for more comprehensive and insightful information gathering. ***This goal was accomplished****. The Juvenile Court Intake Workers completed the COMPAS Youth Training in 2015 so they are now using a semi-structured interview approach during their intake inquiries with youth and their families. This semi-structured interview approach is designed to gather comprehensive information necessary for the COMPAS Youth Assessment Scales through engagement, active listening, and motivational interviewing.*

4. Restructure the recommendations we propose in Juvenile Court Orders so that they are client centered, behaviorally focused, and address the underlying needs of each individual juvenile. ***This goal was accomplished****. A workgroup was formed which was comprised of members of both the Juvenile Court Intake and Ongoing Juvenile Justice Teams. The workgroup first broke recommendations down into categories (i.e. statutorily required recommendations, treatment recommendations, service recommendations, educational recommendations, etc.) and then developed comprehensive recommendations for each of these categories. The categories of recommendations are now archived so that the Juvenile Court Intake Workers and Case Managers can draw from these when preparing legal documents and staff can still tailor them to each individual juvenile, as appropriate.*

5. Continue to provide outreach and intervention to schools and other community partners. This will be accomplished through collaboration with School Liaison Officers and other school personnel on Delinquency and Truancy related matters, as well as through continuing to conduct informational in-services to schools and other community partners on children, youth, and family related issues. ***This goal was accomplished****. The Intake Unit continues to conduct various Mandated Reporter Trainings at the request of schools and community partners, and we continue having meetings with schools and law enforcement to discuss various child welfare and juvenile justice-related topics. In addition, the Intake Unit also continues to be part of the Child Death Review Team, the Sexual Assault Response Team, Watertown's Dialogue for Student Success, as well as our Citizen Review Panel, all with the goal of promoting communication and understanding of each of our roles and responsibilities.*

6. Elicit more information from families regarding their informal supports so that these informal supports can be utilized in situations where safety threats have been identified, thereby preventing out-of-home placements for children and juveniles. ***This goal was accomplished***. *The Intake Unit has always strived to keep families intact whenever possible, and the use of the tools and skills acquired through such evidence based practices as Motivational Interviewing, Family Find, Team Based Practice, and Alternative Response have only strengthened these efforts. The use of these tools and skills is enhancing our proficiency in engaging families at the onset of our involvement which allows for better communication and information-gathering. In most situations, families are more trusting of our involvement and are seeing it as collaborative rather than adversarial so they are more willing to involve their natural supports without feeling scrutinized.*

7. Provide each child that is placed in alternate care with a "Comfort Bag" as to support a feeling and sense of comfort for them. ***This goal was accomplished***. *When it becomes absolutely necessary to place children outside of their homes, the Intake Unit staff does their best to transition children in a way that prevents further trauma. Thanks to the generous donations provided by community members, we are able to provide "Comfort Bags" to these children and we also do our best to ensure children are able to bring some of their own personal and meaningful belongings with them, when possible.*

8. Increase knowledge and application of Trauma Informed Care as evidenced by ongoing participation in the Wisconsin Trauma Project. ***This goal was accomplished***. *The Intake Unit staff attended the kickoff meeting for our Agency in April of 2015, and attended The Effects of Trauma on Children and Adolescents training that same month. One of the Juvenile Court Intake Workers is also part of Tier 1 of the Project and is charged with attending ongoing training, and in turn, sharing this knowledge and expertise with colleagues through "Lunch & Learns" and other informal presentations. Additional training opportunities were also attained in 2015 through attendance at the Secondary Traumatic Stress training and at the Conference on Child Welfare and the Courts: Moving Toward a Trauma-Informed Wisconsin.*

CHILDREN IN NEED OF PROTECTION AND SERVICES (CHIPS)

" Innovatively creating and utilizing evidence based programs, initiatives, and practice standards as a means of achieving safe and timely permanence for the children of Jefferson County."

Child Abuse is a major concern and precursor to many other life problems. Child abuse reports are received from members of the public, including neighbors, relatives and friends of families where abuse or neglect is a concern or potential concern. A large number of reports are also received from schools, police departments, physicians and other service providers or professionals. Each report is handled according to the state legal requirements for child abuse investigation and child protection. Once a report is made, our Intake staff handle the investigations through the court disposition.

Child abuse records in Wisconsin are registered and tracked in a computer based system known as EWISACWIS, (Electronic Wisconsin Automated Child Welfare Information System). This system provides a very detailed computerized system for documenting and reporting child welfare referrals and providing on-going services, including out of home placements. In addition to this, due to Federal Audits of Wisconsin's Child Welfare System, there is additional training, practice and recording requirements for Wisconsin Counties. More time is now required on a per case basis to perform the necessary work and to produce the required documentation. Our workers are required to constantly make judgments that deeply affect the lives of children and their families. These decisions can include removing children from their homes in cases of severe

danger, and requesting intervention of the Court. While other cases do not require action on our part at all, both types of decisions carry potential benefits and consequences for families and for the Department. Once a dispositional finding is made, the Children in Need of Protection and Services (CHIPS) team becomes involved via formal case transfer.

In 2015, the CHIPS and Intake teams continued to refine the case transfer policy as a means of clearly defining worker roles, understanding safety concerns, and following DCF standards. Several practice changes were implemented over the course of 2015 in terms of case transfer between the Intake and Ongoing Case Management (CHIPS) units. First, with the increase of Alternative Response screening decisions and often ensuing Informal Dispositional Agreements, a decision was made to assign a CHIPS case manager directly following the Intake decision to enter into the Informal Dispositional Agreement. This practice allows for a transition with the family between intake and ongoing staff and enhances the engagement process with the family throughout the case transfer process. Secondly, 2015 saw a marked increase in collaboration between Intake and CHIPS in terms of the development of court ordered and Informal Dispositional Agreement terms.

The Children in Need of Protection and Services (CHIPS) team is comprised of a supervisor, eight ongoing case managers and two family development workers. These workers are responsible for monitoring the ongoing CHIPS orders, and forming collaborative plans with families to meet both the elements of the court order and the family's goals.

Once the case is transferred to the CHIPS team, an ongoing case manager is assigned and a treatment plan for the child(ren) and parents is developed. Each case is unique with overriding factors such as poverty, domestic abuse, unmet mental health treatment needs, failure to thrive, reactive attachment disorder, chronic homelessness, criminal charges and sentences, and immigration, to name a few. The CHIPS team works closely to address these issues with internal Human Service providers such as The Workforce Development Center (WDC), Comprehensive Community Services (CCS), Community Support Program (CSP), The Aging and Disability Resource Center (ADRC), The Waiver Program (CLTS), and The Mental Health Clinic as well as Agency Medical Director, Dr. Mel Haggart. The CHIPS team also works closely with community providers including area hospitals and clinics, People Against Domestic Abuse (PADA), local law enforcement agencies, the State Public Defenders Office, schools, and private child placing agencies (CPA).

In 2015, the CHIPS team continued to experience complex case dynamics related to larger societal issues including heroin/opiate abuse and a marked increase in homelessness or problems maintaining housing. Data from 2015 suggests that 22% of all open cases had an element of heroin/opiate abuse involving one or more case participants. Throughout the year, an average of 25% of all children in out of home care under the management of the CHIPS team were in out of home care in part because of heroin/opiate abuse by one or more caregivers. Furthermore, these complex case dynamics require a great deal of case manager oversight in terms of securing treatment options, drug testing, and collaboration with internal and external providers. In June of 2015, a query of worker timesheets revealed that up to 30% of all case manager time was devoted to managing these complex cases.

As the year progressed, the CHIPS team saw a marked increase in the number of families experiencing homelessness or problems attaining housing. The team worked closely with our own internal housing specialist as well as community resources such as Community Action Coalition, St. Vincent De Paul, Jefferson County probation and Parole as well as direct voucher programs with local motels. This noticeable increase in housing issues can be traced to ineligibility as it relates to low-income housing, lack of income, legal barriers such as prior evictions, and unemployment. At the close of 2015, close to 10% of our caseload was experiencing some form of housing difficulties. As we look forward to 2016, the CHIPS team will be challenged to become better versed in landlord/tenant rights and to expand our knowledge base as it relates to housing resources.

The CHIPS team approaches each case with goals aimed at ensuring the safety of the children involved while at the same time providing for their permanence. If the children were placed outside the home at the time of disposition, permanence options include reunification with parent(s), Ch. 48 Subsidized Guardianship, Ch. 54 Guardianship, Termination of Parental Rights and Adoption or aging out of care.

In 2015, the Jefferson County Human Services Child Protective Services Unit continued their membership in a consortium with Green and Rock counties aimed at improving child safety through the production of Standards based Safety Planning. The IHSS (In-Home Safety Standards) consortium meets quarterly to review existing In-Home Safety Plans. This standards based, peer review process allows for a structured environment to present, review, and refine existing Safety Plans. The goal of this process is to identify safety threats and create safety control based tenets as opposed to treatment based tenets. In 2015, members of the CHIPS team attended each quarterly consortium meeting and a representative of the CHIPS Team or other Children and Families Division unit made case presentations at each meeting.

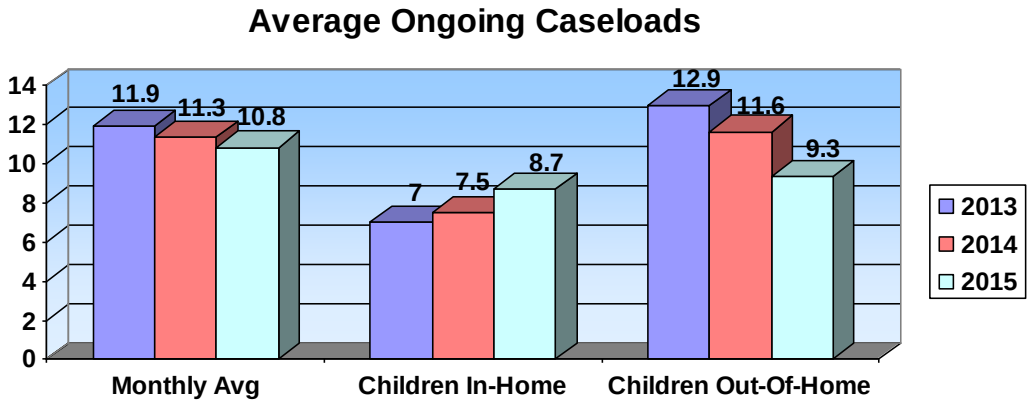
In 2015, the CHIPS team continued to take part in the Permanency Roundtable series. A Permanency Roundtable (PRT) is an intervention designed to facilitate the permanency planning process by identifying realistic solutions to permanency obstacles for children. The PRT protocol invites key players such as State Permanency Consultants, Policy Experts, External Consultants, trained facilitators, case managers, and the team supervisor to take part in a formalized, prescribed case consultation process. The process is initiated by a formal case presentation by the assigned case manager. The team is then allowed to ask questions of the case manager and supervisor as a means of clarification. This is followed by a brainstorming session whereby any and all ideas are welcomed. The case manager is then allowed to choose new avenues to explore in terms of achieving permanency for the cases being reviewed. Finally, the permanency outcomes for all of the children are rated on a continuum from poor, uncertain, fair, good, very good to permanency achieved. In 2015, the team hosted seven (7) days of Permanency Roundtables consultations. These consultations involved 13 cases where the permanency for 17 children was discussed. As a result of these consultations, the Permanency rating for 15 of 17 children improved or stayed the same. More importantly, five (5) cases involving nine (9) children reviewed during the seven rounds improved to a rating of good or the children reached Permanency prior to the actual scheduling of the next round. Finally, in 2015, eight (8) children were reunified with their parents in part because of the PRT consultation process.

In 2015, the CHIPS team continued to utilize the Subsidized Guardianship program as highlighted in 2011 Wisconsin Act 181: Best Outcomes for Children. The implementation of the Subsidized Guardianship program is now more clearly defined in the Ongoing Standards and in 2015 the CHIPS team successfully petitioned the Jefferson County Circuit Courts on behalf of four (4) children. Also, in terms of the use of Guardianship, the CHIPS collaborated closely with the Jefferson County District Attorney's Office and the Courts to help one (1) child find permanency with relatives under more traditional Ch. 48 Guardianship proceedings. The choice of and use of certain types of Guardianships to help children achieve permanency is largely dependent upon the types of benefits the child and guardian may receive following the Court's granting of the Guardianship. The CHIPS Team strives to use the most appropriate form of Guardianship on every case where Guardianship is the identified permanency goal.

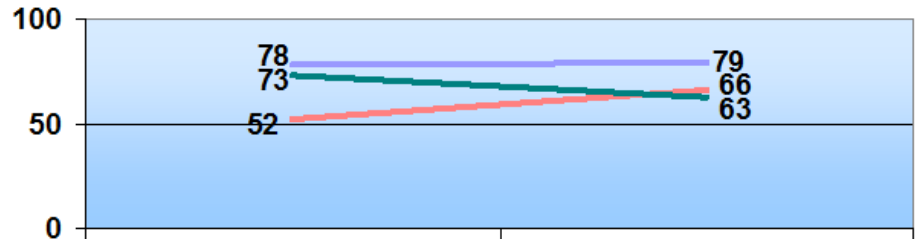
In 2015, when fully staffed, the eight (8) ongoing case managers carried an average of 10.8 cases or about .5 less cases per worker than in 2014. The average caseload for the year included responsibility for an average of 8.7 children placed in home which is up 1.2 children from 2014 and can be viewed as a very positive trend towards fewer petitioned Circuit Court cases and a marked increase in Informal Dispositional Agreements. Ongoing case managers closed the year averaging 9.3 children placed outside the home which is down 2.3 children from 2014. This is a significant reduction directly attributable to enhanced Safety Planning, trial

reunifications, increased collaboration with legal partners, Alternative Response, and bi-weekly permanency tracking for all out of home cases. These raw numbers are very meaningful in terms of overall case counts

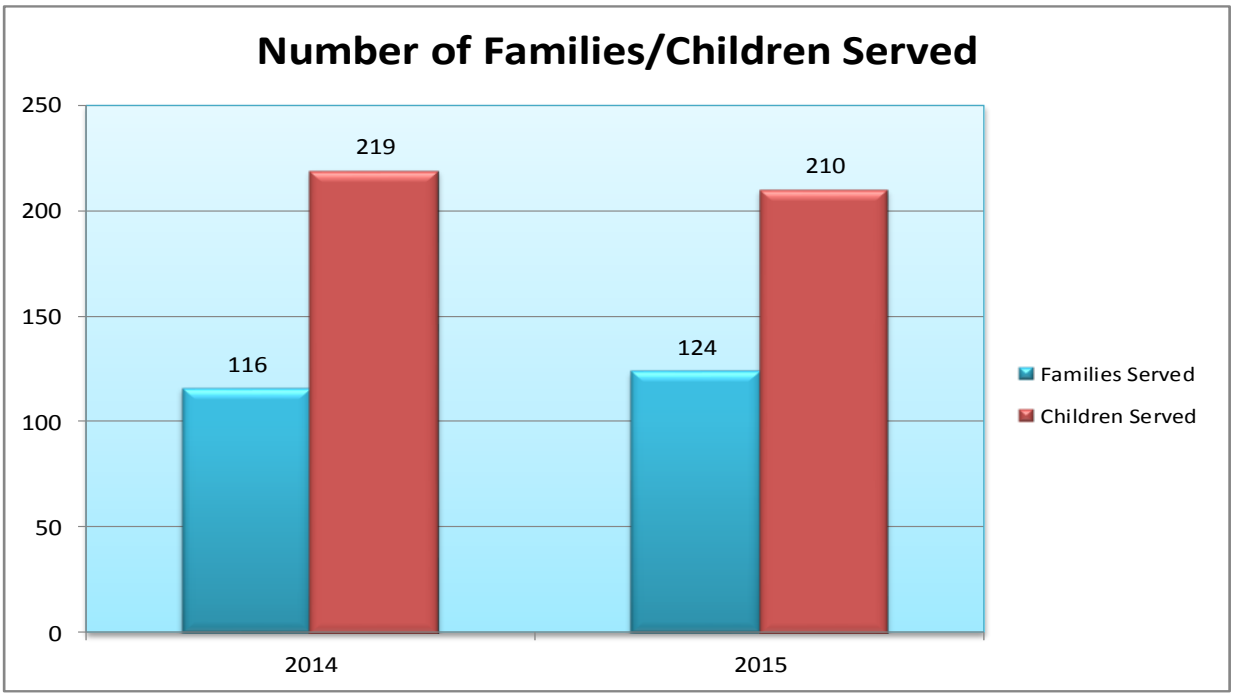
however they reveal very little about case activities as they relate to initiatives, assessments, case planning, document production, and engaging families.



At the start of 2015, there were 78 open cases and at the close of 2015 there were 79 open cases or an increase of 1%. With regard to out of home care, the CHIPS team was responsible for 73 children placed in out of home care at the start of 2015 and 63 children placed in out of home care at the end of the year or a reduction of 14 %. The CHIPS team oversaw 52 children subject to in-home orders at the start of 2015 and there were 66 children subject to in-home orders at the close of the year or an increase of 22%. In 2014 the CHIPS team served 116 families comprised of 219 children, where as we saw that number increase in 2015 to 124 families served with 210 children.



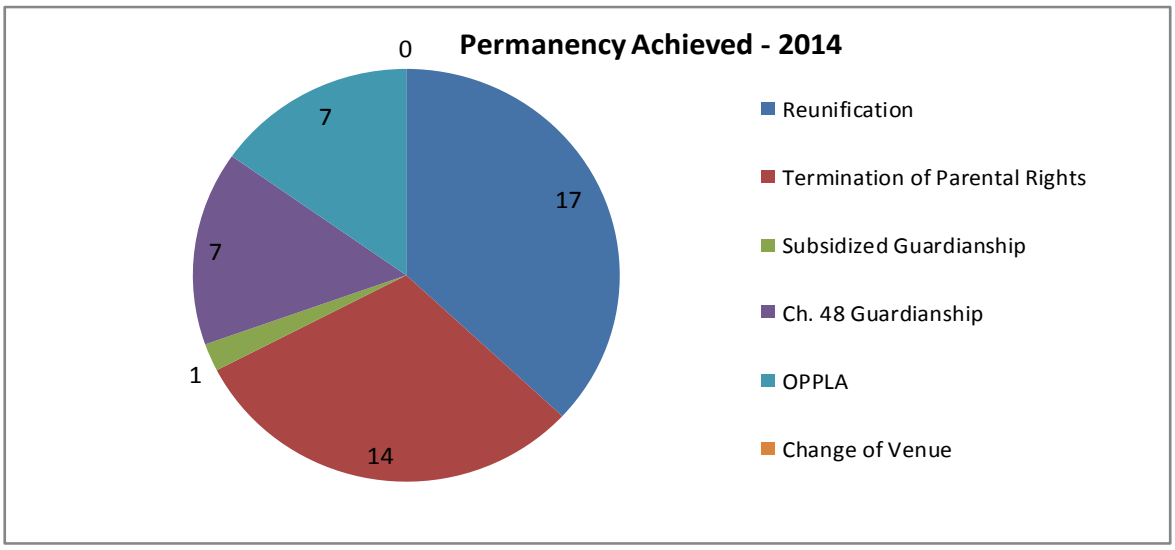
	Start of 2015	End of 2015
Number of Open Cases	78	79
Children In-Home	52	66
Children Out-of-Home	73	63

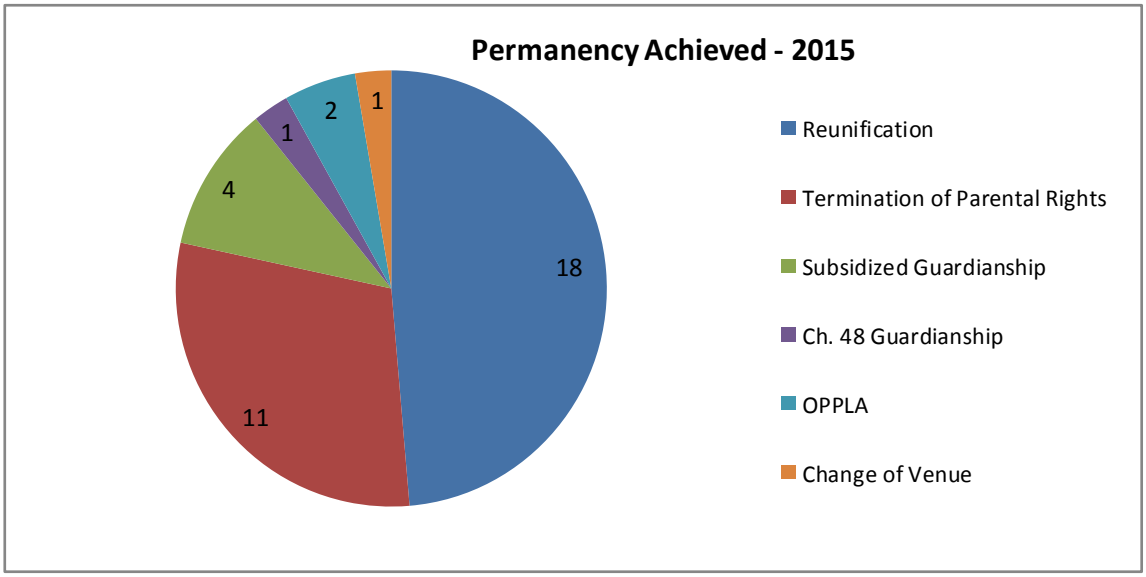


The number of children subject to in-home orders is a direct result of decreased court intervention through Alternative Response, an increase in the number of assigned Informal Dispositional Agreements, and an increase in our overall rate of reunification. Once children are placed back in home with their parent(s), the order remains open for one year. These numbers clearly demonstrate that fewer children were being subjected to the trauma associated with placement outside their home.

Over the course of 2015, the CHIPS team was assigned 46 new cases. These cases are assigned primarily from three (3) sources. A majority of these cases (39) were assigned to the CHIPS team from our Intake unit. These cases are a combination of both formal circuit court orders and informal dispositional agreements. The CHIPS team was assigned four (4) cases via Courtesy Supervision requests from other counties in Wisconsin. These requests generally mean a parent or child moved to our county while on supervision in another, forwarding county. The final source of case generation is Interstate Compact (ICPC). These cases generally require supervision by our county at the request of another, forwarding state. These cases at times require supervising children placed in our county by another state or they require a home study by our county to ascertain the safety and feasibility of placing an out of state child in a home in our county.

The generation of these new cases was offset by the closure of 45 cases. Safe case closure can be the result of reunification and up to 12 months of careful case monitoring. Case closure can also be the result of other forms of permanence being achieved such as Termination of Parental Rights, various forms of Guardianship, OPPLA (age out in care), transfer to adult services, and the closure of an in-home case without further service needs or safety related concerns. Twenty eight cases or 62% of the 45 case closures were closed due to the safe expiration of the circuit court or informal dispositional agreement order. These cases involved children never placed outside the home or children previously outside the home but safely reunified with one or both parents. The remaining 17 safe case closures were the result of administrative closings following Termination of Parental Rights, Guardianship, OPPLA or through the closure of Courtesy Supervision or ICPC case assignments.





In 2015, the CHIPS team helped 37 children find permanency. Eleven children were the subject of Termination of Parental Rights proceedings including three sibling groups of three or more children. All were successfully adopted or were in the process of being adopted at the start of 2016. Eighteen children were reunited with one or both biological parents after having previously been placed outside the home. Of these 18 children reunified with one or both parents, two children unfortunately re-entered care due to new allegations of neglect. Five children found permanency with relatives via Guardianship in accordance with their court approved Permanency Plans and four of these Guardianships were part of the Subsidized Guardianship initiative. Two children found Permanency via (OPPLA) meaning they turned 18 while still placed in care and are living independently at this time.

The Jefferson County Human Services CHIPS team and the Children and Families Division as a whole prides itself upon taking part in DCF initiatives aimed at improving our practice. These initiatives in conjunction with the National Association of Social Workers Code of Ethics as well as our own Code of Conduct ensure that the children and families of Jefferson County are receiving the highest level of care and services as it relates to Child Protective Services.

The CHIPS team works closely with many internal and external service providers in order to achieve desirable case outcomes. The CHIPS team enjoys the support of two family development workers. The primary role of the family development worker is to supervise family interaction between parents and children placed out of home, however providing court room testimony and one-on-one services are now becoming more prominent. The purpose of the family development worker's position is to provide services to families and assist case managers in placing children in-home on a permanent basis; this includes providing in-home services when children remain placed with their parents as well as services to assist families in getting their children placed back in the home when they are in out-of-home care. This is achieved by supporting families through one-on-one modeling/teaching of parenting skills, providing transportation to various appointments, and tracking and documenting client progress as it relates to set goals. Family development workers are the eyes and ears of the case managers as this role involves seeing many of the case participants on a more frequent basis. The family development workers are also involved with the Incredible Years parenting class as co-facilitators.

When a family development worker becomes involved in a case, they receive a referral from a case manager that includes parent and child information, a brief description of why services are being requested, what those services are, any special needs related to the children or parents, and client strengths. This allows us to provide individualized services based on the needs and strengths of each client. One-on-one services can include, but are not limited to, help with parenting skills, budgeting and finances, and cleanliness and safety of the home environment.

One-on-one parenting services are based on specific client needs but staff often pulls from the Incredible Years curriculum due to their involvement in teaching that program. The Incredible Years is an evidence-based parenting program that was established by using 25 years of research by Dr. Carolyn Webster-Stratton who is a licensed clinical psychologist, professor, and director of the Parenting Clinic at the University of Washington. The classes offered vary by the following age groups: 0-1, 1-3, 3-6, and 6-12. The programs for each age group vary in length from 8 weeks to 18 weeks. Classes include watching vignettes, discussing those vignettes, role playing, games, quizzes, and homework which includes documenting use of the skills learned and discussed in class as well as reading chapters from the Incredible Years book. The program is based on a pyramid with the premise being that we want to do more of the things on the bottom and less of the things at the top. The skills at the bottom are focused on building a positive relationship with your child and increasing their positive behaviors. Those things include spending quality time with them and using praise, encouragement, and rewards. In the middle of the pyramid is establishing household rules, clear limits, and the importance of following through with those rules and limits. At the top of the pyramid are ways to handle misbehavior such as ignoring, distracting, redirecting, and consequences (timeouts and/or removal of privileges). To use this in one-on-one sessions we either formally do an in-home version of the program or individualize the sessions and pull from the Incredible Years curriculum and other resources as needed.

This year, the supervised visitation room located at Jefferson County Human Services was equipped with video/audio recording equipment which allowed staff to record client sessions. This gave staff the opportunity to review sessions and continue to fine-tune our approach even further. In the future staff will be able to use this equipment to provide Parent-Child Interaction Therapy, or PCIT. PCIT is used to improve the quality of parent-child relationships and change the parent-child interactions. At times family development staff will partner with legal professionals as well as other Jefferson County Human Services professionals, such as mental health workers, to put together individualized parenting programs for clients. It involves a therapist watching the parent and child through a one-way mirror and coaching that parent using a microphone and ear piece.

Supervision of visits also varies from case to case. Sometimes staff will take a more hands-on approach by modeling and giving suggestions or prompts throughout the visit, other times staff will take a more passive role during the visit and provide feedback afterwards if necessary. Additionally, in order to make visits occur, family development staff frequently provides transportation for the children and/or parents. When possible,

visits take place in their own home environment. For cases in which that is not possible, they take place somewhere in the community or in the visitation room at the Human Services building.

In the last year the family development workers took part in a focus group targeting the development and implementation of a structured referral, feedback, and case note documentation form. The referral form is a resource the case managers utilize to refer new clients to the family development workers. This form lays out the specifics of the case and the services needed. The feedback form is utilized by the family development worker to provide structured feedback to parents in regard to improving parent child interactions. The family development worker recognizes and builds off of parent strengths as well as provides recommendations on how to improve upon identified deficits. These forms also allow the family development worker to monitor client progress in regard to given feedback and implementation of taught skills. The focus group also produced a structured case note documentation form. This form is specific to supervised visitation conducted by the family development worker. It focuses on the specifics of parent child interactions. It requires the family development worker to document how both the parent and child react and interact with one another. This targeted documentation assists in understanding the relationship between parent and child, as well as provides insight to services needed.

In the last several years, the CHIPS team has taken part in several initiatives aimed at improving our practice and improving outcomes for children and families in the CPS system. Since 2012, the CHIPS team has taken part in Subsidized Guardianship training, Family Find, Motivational Interviewing, In-Home Safety Services (IHSS) and Team Based Practice. As we look forward to 2016, the CHIPS team will continue to adapt our practice in accordance with recent initiatives and trainings. All members of the team completed an agency wide initiative and training series focused on Motivational Interviewing (MI). Motivational Interviewing is a collaborative, person centered form of guiding to elicit and strengthen motivation to make meaningful change. The fidelity of this collaborative form of communication is important to the team because as we move forward in 2016 and we plan to use transfer of learning exercises during team meetings and to make M.I. a focus on every case during worker supervision. Additionally, several more trainings are scheduled throughout 2016 to enhance MI practice and to train additional staff to become trainers themselves. Having qualified individuals on staff to train new employees and to enhance current practices will ensure the fidelity of this initiative for years to come.

In 2015, the Children and Families Division Manager applied for membership in the DCF led Post Reunification Support Program (PS) aimed at reducing re-entry into alternate care once a child is reunified with a parent. We were accepted as a pilot county and members of our staff took part in program development and eligibility requirement call-ins and seminars throughout the course of the year. This program determines the eligibility of children based on a variety of factors such as length of time in care, exposure to trauma based on Child and Adolescent Needs and Strengths (CANS) ratings as well as a variety of factors related to their familial structure. In essence, once a child previously placed outside the home is reunified with one or both parents, that target child and family are eligible for federal grant monies aimed at ensuring proper service and safety provisions, housing, transportation, recreation, and educational opportunities to prevent re-entry into alternate care. In 2015, five targeted children and families selected by the CHIPS team were enrolled in the program and all five families were intact at the close of the year. This important initiative is aimed at preventing children from re-entering out of home care and for the year, the program was a rousing success.

The challenge as we look forward to 2016 is to maintain the fidelity of these trainings and initiatives and to continue to modify our practice as new challenges arise. Practice change and modification will require increased transfer of learning exercises and more targeted supervision on each case. The CHIPS team has staff with a great deal of training and experience and several members of the team are key contributors or actual trainers in Motivational Interviewing and Trauma Informed Care. Having these resources available to the entire CHIPS team on a consistent basis will ensure that the team is able to meet challenges in 2016.

Review of 2015 Goals:

1. **The Children in Need of Protective Services Key Outcome Indicator was that all new out of home placements shall be formally screened for Permanency within 90 days of case manager assignment.** In 2015, the CPS Ongoing Unit received 14 new out of home placements. All 14 cases were formally screened for Permanency within the 90 day timeline.

2. The CHIPS ongoing case management team will update all applicable Policy and Procedure to digital format by 12/31/2015. This can measured via completion and posting of the online manual. ***This goal was accomplished***. The Children and Families Division has worked as a unit throughout the course of the last 15 months to convert applicable policies and procedures into electronic format. In addition, new DCF initiatives and practice requirements will be added to the electronic format as they arise.

3. In order to comply with DCF Ongoing Standards, the CHIPS ongoing case management team will develop and institute a system whereby all Case Plans are drafted, reviewed, and approved within the 60 day timeline set by DCF. This can be measured via institution of the system and through regular review during worker supervision and Team meetings. ***This goal is in process*** as the State of Wisconsin Department of Children and Families rolled out an electronic tracking system through a eWisacwis task pane. This task pane can be accessed by the CPS Ongoing Supervisor as well as the ongoing team.

4. Each case manager will accomplish a Family Team Meeting in accordance with the Oct. 7-10, 2014 Family Teaming training. This goal can be measured via verification of scheduled and completed Family Team Meetings. ***This goal has been accomplished***. All ongoing CPS staff completed Family Teaming as well as Family Find practice modules. These trainings have resulted in an increased interaction with case stakeholders including parents, guardians, children, as well as formal and informal service providers.

5. As a means of maintaining the fidelity to the Family Find training series, each case manager will complete an element of Family Find such as Seneca Search, Connectedness Mapping, or Mobility Mapping. Each case manager will present their completed element to the Team via transfer of learning. This goal can be measured via completion during Team meetings. ***This goal has been accomplished***. Each Case Manager has used at least one element of Family Find on their caseload in the last year. These exercises and the associated transfer of learning exercises have directly led to permanency for children on our caseloads and a deeper understanding of the value of these tools in terms of family engagement amongst Case Managers.

6. Each CHIPS ongoing case manager will complete Trauma Informed Care training in 2015. This can be measured via certificate of completion. ***This goal has been accomplished***. Each ongoing case manager completed the TIC training series in 2015.

7. In order to comply with federal and agency benchmarks, all out of home care face to face case notes will be entered within 24 business hours. This can be measured via the development and institution of an internal tracking system. *This goal was part of a change project for 2015.* ***This goal has not been accomplished****;* however note entry time was still reduced by over 70% over the course of the year as a result of the change project. As we move into 2016, eWisacwis task pane functionality will allow for real time tracking of this measure.

2016 Goals:

1. **Key Outcome Indicator: All new out-of-home placements will be formally screened for permanency options within 90 days of case assignment to ongoing staff.**

2. All formal, court ordered CPS cases will be screened for the need of assessments including but not limited to parenting skills, AODA, bonding, psychological, neuropsychological, domestic violence or psycho-sexual assessments within 90 days of all formal petitions. All informal dispositional orders will be screened using the same parameters within 30 days of case transfer.

3. The CPS Ongoing Unit will develop an internal case plan tracking system outside of current SACWIS based systems in order to comply with DCF and Federal guidelines.

4. The CPS Ongoing unit will take an active role in developing case specific court recommendations with our internal and external providers. This goal will allow for more case specific, measurable, and cohesive dispositional orders and allow for a more seamless transition from Initial Assessment to Ongoing.

5. The CPS Ongoing Unit will expand the yearly Incredible Years parenting program from two sessions per year to three sessions per year.

6. Members of the CPS Ongoing unit will expand their role in terms of community outreach as it relates to Trauma Informed Care.

JUVENILE JUSTICE INTEGRATED SERVICES

"We must understand that our youth come to us with deep wounds and look at both the strengths and needs that each one of our kids has, with the hope that they will feel encouraged and supported to achieve success"

The Juvenile Justice team is comprised of the Division Manager, Juvenile Justice Supervisor, six case managers and two Intensive Community Outreach Workers. The Juvenile Justice Integrated Services Team provides ongoing case management for youth on Juvenile Delinquency orders, Juvenile in Need of Protection or Services (JIPS) orders, Consent Decrees, Chapter 51 orders, Deferred Prosecution Agreements, as well as voluntary cases. The Juvenile Justice team recognizes the dignity of each and every youth. Being at the forefront of the statewide trend to go away from the punitive, "mini adult" probation model, the Jefferson County Juvenile Justice Team values:

- Engagement of youth and families
- Trauma-Informed care
- Goal-driven targeted case management
- Family, treatment focused service delivery
- Development of natural strengths and supports to enhance the positive, pro-social qualities of our youth
- Trained and committed juvenile justice professionals and community partners

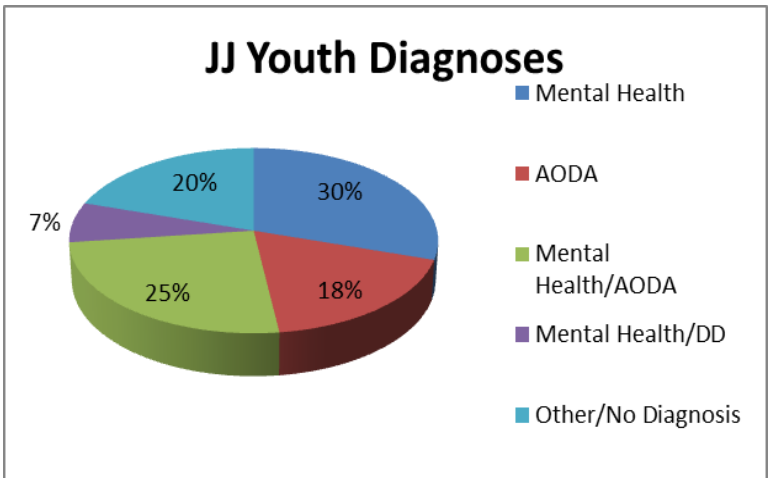
- Community safety
- Utilization of effective evidence-based strategies and promising practices
- Fair and equitable treatment of youth and families
- Continuum of services based on assessment of youth risk and needs
- Prevention of youth involvement in the juvenile justice system
- Joining with other systems, including but not limited to child welfare, education, and mental health, to develop a team approach to serving youth

Our team strives to meet the unique needs of youth while assuring a safer society. In line with the Wisconsin Juvenile Justice Practice Model, and to be effective in preventing juvenile delinquency and future criminal behavior, we utilize a risk assessment tool to identify risk factors early on, including prior adjudications, peer group, participation in prosocial activities, level of remorse, drug use, educational goals, family discontinuity and family's involvement in the criminal justice system. We understand the importance of working with youth, their families, and their support systems to enhance and encourage success.

Targeted Case Management

The Juvenile Justice team has been providing targeted case management, both as a billing source and for overall best practice, for approximately six years. Targeted case management includes a comprehensive assessment of the juvenile and his/her family. During the assessment, the case manager looks at several different life domains, including trauma, life satisfaction, strengths, mental health, family functioning and others. A goal driven case plan is created with the youth and family to determine what the case manager will assist with and what services need to be put in place. The plan is reviewed regularly with the youth and family, and a new plan with new goals is completed every six months. In addition to the treatment benefits of this practice model, $79,104.25 was billed to Medicaid in 2015, and the Department received $17,833.76 in payment.

Issues and Challenges



The youth served by the Jefferson County Juvenile Justice team come with multiple strengths and needs. Many of the youth that are in the juvenile justice system of Jefferson County have been diagnosed with mental health disorders and developmental disabilities. Several carry trauma with them, which can lead to emotion dysregulation, alcohol and/or drug use, poor impulse control, poor social skills and antisocial behaviors. In review of 2015, there was a slight rise in youth with multiple diagnoses, such as youth with mental health and AODA and youth with mental health and developmental disabilities. Most notable is that 80% of the youth served in the Jefferson County Juvenile Justice Program had some sort of diagnosis as noted in the following graph. In response to this, Jefferson County has taken a treatment based approach to juvenile supervision, working to get to the core of the issues and building competencies rather than punishing children for violations that can be best addressed in a therapeutic manner.

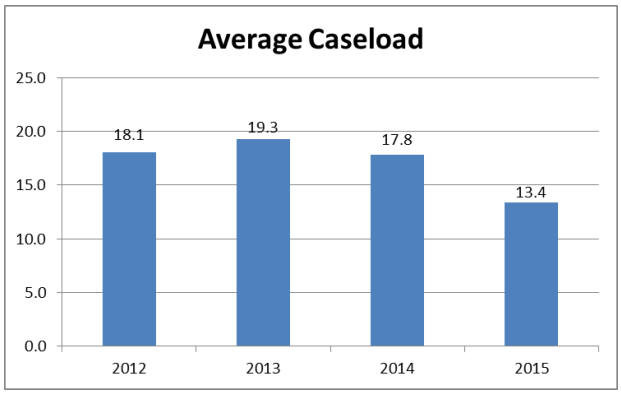
Jefferson County Highlights Youth Strengths to Improve Programming

The Jefferson County Juvenile Justice team has worked hard over the last year to ensure that youth programming is in line with the values and principals of the Wisconsin Juvenile Justice Practice Model. In 2015, the team enhanced the Community Outreach/Intensive Supervision Program, which focuses on building youth competencies through the use of incentives. Youth in the program earn points for a number of activities and positive behaviors, including taking responsibility to meet with their worker each day, attending therapy sessions, attending school programming, following house rules, completing homework, completing community service, searching for a job, joining a sport or other extracurricular activity, practicing coping techniques, and many other acts and behaviors that show they are living positive, healthy and safe lives. Some of these incentives are free, such as extra free time, one on one time with a parent, reducing the amount of contact they receive from the worker, etc. Others include material items that the county provides. In order to provide these items, the team approached several youth on supervision who have expressed an interest in art to make drawings to be included in a 2016 calendar. The response was great, with six young artists submitting work. With the help of an article in the Jefferson Daily Union and a spot on WFAW Morning Magazine, the calendars were sold throughout Jefferson County. This project raised over $250.00 and got the new programming off the ground. It was wonderful to see our community rally behind our juveniles and support their efforts to become happy, healthy, productive, contributing members of their communities.

Intensive Supervision/Juvenile Community Outreach Workers have a smaller caseload so they can devote a great deal of time to the youth they serve. Juvenile Community Outreach Workers partner with the ongoing case managers to offer in-house services such as Aggression Replacement Training groups for juveniles who need to learn additional anger management tools, Prime for Life AODA education classes and Juvenile Cognitive Intervention Programs; all evidenced based models. We remain focused on reducing and preventing placements of our youth (i.e. secure custody and respites) while also ensuring the safety of our community, and these interventions help us to make that possible.

It is estimated that the services mentioned above, in conjunction with solid case management and good collaboration with contracted providers, such as Connections Counseling, Community Care Programs (STOP treatment for sexual offenders) and Connections Counseling AODA therapy, as well as in-house providers such as Jefferson County Coordinated Services team, Comprehensive Community Services and Community Support Program, have helped to maintain the in-home placements of 113 youth in 2015. Out of the youth who did ultimately experience an out-of-home placement, 94% of those were community placements. In addition to serving our philosophical goal of keeping families together, out-of-home placements are costly and we are confident these comprehensive services have reduced costly out-of-home placements and saved the county money.

The average caseload per worker decreased in 2015 due to the addition of a Juvenile Justice worker at the beginning of the year. The lower caseload was necessary so that the workers would be able to deliver the quality level of services that are essential to good juvenile justice practice. This is reflected at right.



Trauma Informed Juvenile Justice Programming

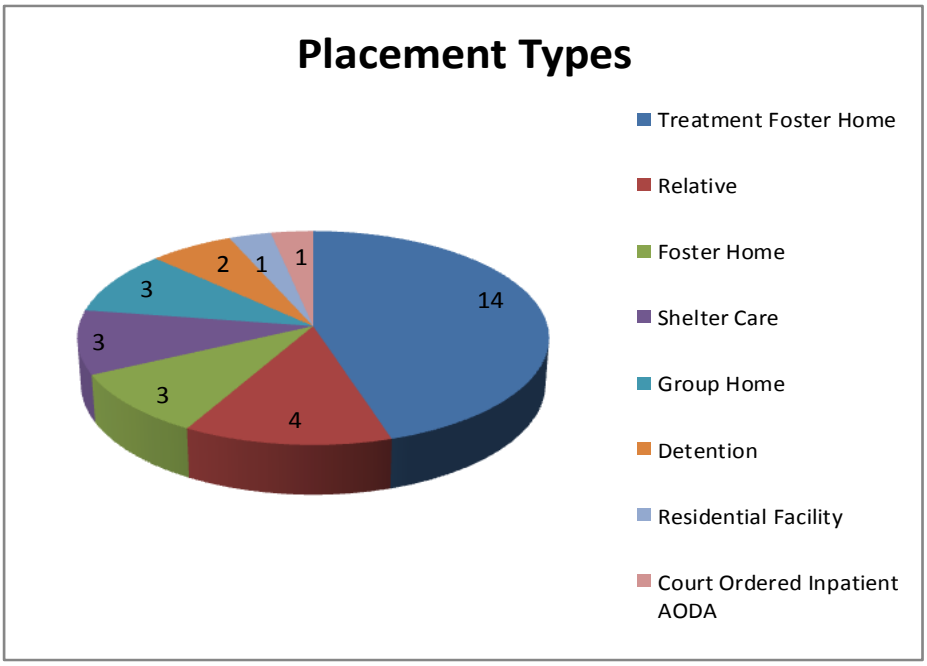
The Juvenile Justice team continued to see an increase in juveniles who struggle with symptoms related to the

trauma they've experienced in their lives. The behaviors that often result from traumatized youth can be incredibly challenging for parents, caregivers schools, service providers and Juvenile Justice Workers. Folks involved with these youth often look to the Juvenile Justice Worker to address the behaviors, more often than not in a punitive way, and we as an agency have learned that punitive responses on a system level can cause great harm to traumatized youth. We still take our responsibility to address individual and community safety very seriously and take action to account for safety when necessary. However, our entire decision making focus is through a trauma lens, and the ultimate goal is to address safety concerns in a way that will not bring further harm and trauma to that youth.

Through a partnership with the Department of Children and Families and the Trauma Informed Care Project, our entire team received excellent training in 2015 on the effects of trauma on children, how we can best help and serve them and how traditional services may have exacerbated the behaviors related to their trauma. Additionally, one team member received more extensive training in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and another team member received more extensive training in trauma informed parenting. The Trauma Informed Care Project has helped immensely in creating a trauma informed juvenile justice program, and we look forward to the third tier of this project when the department as a whole provides trauma training to our area school partners.

We know that removing youth from their homes, as dysfunctional as they might seem, (to those involved with them) can be incredibly traumatic for those children. When placements are necessary to address community safety and treatment for the juvenile, our team strives to keep our youth in the least restrictive environment, preferably a family setting. The total number of juveniles who experienced some type of out-of-home placement in 2015 was 20, with 33 total placements. Despite our strong drive to maintain all of our youth who require placement in relative, foster or treatment foster homes, 52% of our total out-of-home placements were in family settings. This speaks to the high level of needs that these youth had at the time of placement and the demand for specialized treatment providers to address some very difficult, and in some cases, dangerous behaviors.

The following chart reflects the total placements. It should be noted that some of these youth experienced multiple placements as they stepped down from a more restrictive placement or were moved to a higher level of care. Our team also strives to address the needs of our juveniles while protecting the community in the least restrictive placement setting to minimize and prevent further trauma. At times, this takes a great deal of planning and coordinating additional services to support placement providers in accommodating the needs of these youth. Our efforts were successful in 2015, as we had the highest number of placements in our county foster homes, no correctional placements and only two placements in a county juvenile detention center.



The Juvenile Justice team partnered with the Maintenance team to complete a project that aimed to reduce the cost of the Juvenile Justice team's mileage by two percent. We placed a key hook in one of the cubicles and hung the key to the squad assigned to our team when the car was not in use. This gave JJ team members better access to that agency vehicle, allowing it to be utilized and not sit in the parking lot. It was a successful project, and the team exceeded the goal by reducing staff mileage by 2.75 percent. In addition to that, the team helped workers to create a shortcut to the vehicle schedule and surveyed the agency to determine barriers to utilizing the agency vehicles. Though we could not address the overall lack of availability, we did address other concerns, such as vehicles being left dirty and not having enough gas. We placed laminated cards reminding folks to throw away all garbage and fill the cars with gas if they were at a ½ tank or less. This has led workers throughout the agency to feel more positive about utilizing these vehicles, and maintenance has reported that more people than ever are looking at the schedule and asking about using a vehicle.

Review of 2015 Goals:

1. **The Key Outcome Indicator in 2015 was that 95% of children on formal supervision would remain in the community through the use of community based safety plans and treatment.** This key outcome indicator was met (KOI) in 2015. 95% of children who were on formal juvenile supervision in 2015 maintained placement in a community setting with community based safety plans and treatment services. Due to a small number of children on supervision in 2015, who presented with a very high level of need, one child was placed in a limited term secure detention program for a period of time, and five children were placed in residential treatment facilities. Two of those youth have now moved to family settings.

2. To increase independent living and self-sufficiency skills in the youth we serve, the team will facilitate an ongoing life skills group, as evidenced by higher scores on post-tests. **This goal was accomplished.** In 2015, 100% of the young women who participated in this group indicated higher self-sufficiency skills. However, this group was very difficult to sustain on an ongoing basis due to a lack of participants. Juvenile Community Outreach Workers focused their efforts on individual skill building after learning there were not enough youth to run additional groups.

3. To increase our resources and continue to make improvements in our program, the team will explore various funding opportunities to finance additional tools to guide our practice. **This goal was accomplished.** The Juvenile Justice Team partnered with youth receiving our services to create a 2016 calendar with art submitted by the youth themselves. These calendars were then sold to community partners to raise money to fund activities or items that kids can earn by making positive contributions to their communities.

4. To decrease recidivism, the team will take the necessary steps to update our risk assessment tool. **This goal was accomplished.** The Jefferson County Juvenile Justice Team is now fully trained and utilizing the COMPAS risk assessment tool to guide decisions and practice around low, medium and high risk offenders.

5. To increase connections, natural supports and permanency options, Juvenile Justice Case Managers will implement the tools learned through Family Find trainings with 100% of our youth placed in out of home care. **This goal was accomplished.** All children placed out of home through a Delinquency or JIPS order were offered some level of Family Find services in 2015. Some of the youth who were offered less tools had difficulties grasping the concepts due to intellectual abilities or higher levels of emotional disturbance. Most of the youth were offered an array of Family Find tools; and the results in many cases were incredibly positive, increasing the number of supportive connections for those young people.

6. No less than 80% of youth with a diagnosed mental illness who receive services through the Juvenile Justice program will have a crisis plan. **This goal was accomplished.** As part one of our projects in 2015, the Juvenile Justice Team created a process to implement a practice to create a crisis plan for every one of our juveniles who is served by our team.

7. All Juvenile Justice Team members (100%) will participate in advanced motivational interviewing training in 2015. **This goal was accomplished.** All members of the Juvenile Justice Team received additional training in motivational interviewing and submitted an additional tape to be reviewed and scored by the company contracted to assist us with this.

8. To improve processes in identified areas, the Juvenile Justice Team will complete a minimum of two projects in 2015. **This goal was partially accomplished.** The team completed one Project on increasing the use of agency vehicles, thus reducing the amount of mileage claimed by the team. The team is almost to the end of the second project of increasing the number of youth who have a crisis plan on file. At this time, we have created the new process and are testing it out to see if there are additional ways to simplify the process.

2016 Goals:

1. **Key Outcome Indicator**: 90% of Jefferson County Youth on Juvenile Supervision will reside in a family setting.

2. The Juvenile Justice Team will increase the amount of community based early intervention and prevention services, as evidenced by providing the Wellness Recovery Action Planning group to a minimum of two school districts in 2016.

3. To highlight the value and keep at the forefront of providing good practice to the youth who receive Juvenile Justice services, a Juvenile Justice team member will research and present on an evidenced based or promising practice, or an article that emphasizes an issue that impacts the juvenile justice field. This will occur monthly in 2016.

4. The Juvenile Justice Team will increase the level of family based service delivery, as evidenced by the use of integrated crisis plans with all families and additional services offered to Juvenile Justice family members, such as parenting classes and referrals to outside providers.

5. The Juvenile Justice Team will collaborate with parents and placement providers to offer additional positive activities for our youth, as evidenced by 3-5 structured events being offered throughout the year.

6. The Juvenile Justice Team will create a workgroup to address the unique challenges specific to youth on supervision for truancy.

7. The Juvenile Justice Team will address the effects of secondary post-traumatic stress, as evidenced by incorporating monthly team building exercises and activities into our team meetings.

8. To improve processes in identified areas, the Juvenile Justice Team will work on a minimum of two additional projects in 2016.

Restorative Justice Programs

"Opportunities Inc. contracts with Jefferson County Human Services to provide Restorative Justice Program options to youth who have offended to ensure they are positively restored to their communities."

Teen Court

Teen Court is a community based program for first time and minor repeat offenders. It offers eligible youth an opportunity to receive a meaningful sentence from a jury of their peers in lieu of appearing in circuit court and paying their citation. Youth who successfully complete the program will have the charge dismissed from their record.

The Jefferson County Teen Court program was established in 1998. In 2015, there were 25 Teen Court participants. Completion statistics are as follows:

	Participants	Percentage
Successful Completion	22	88%
Active in the Process	1	4%
Unsuccessful Completion	1	4%
Chose to Withdraw	1	4%

Participants are required to serve on the peers jury for other participants. The jury determines the sentence which may include options such as apology letters, community service, and various projects or activities. Participant feedback from the Teen Court experience included the following comments.

- "If you do a crime you have to work to get things right again"
- "It's taken very serious to all who attend it"
- "It's a great experience to go through"

Referral sources for this program include Jefferson County Human Services, Police Departments, and Municipal Courts.

Cost-benefit analysis reports completed in the past have concluded that the Teen Court Program affords Jefferson County not only financial savings but also great rewards while participating in restorative justice processes. It is also noteworthy to mention that no referrals were made for a repeat offense in 2015.

Community Service

While performing Community Service, juveniles are being held accountable for their actions and restoring the community in a positive manner. Staff assist youth in planning for and facilitating options to reach their commitment to community service through both supervised site options and customized activities completed independently.

The Restorative Justice Program of Jefferson County has been providing community service supervision for youth since 1997. In 2015, the Restorative Justice Team worked with 62 community service participants. During the year, 33 completed their order with 85% successfully fulfilling expectations by completing their community service plan.

The Restorative Justice Team takes a creative and individualized approach when planning community service plans with participating juveniles to increase the probability of follow-through. The Restorative Justice Program offered as many as 5 weekly supervised community service sites and included doing recreational

activities with the residents of assisted living facilities, cleaning, or setting-up activities for community organizations like the YMCA of Watertown, Bread and Roses, and Head Start.

Throughout the year, 37 community service events were also offered at a variety of locations across the county. Twenty-seven events occurred with a total of 34 participants that completed over 75 hours of community service. Community events included the Watertown Community Action Day, Fort Atkinson's Share and Care Fair, Jefferson County Fair Park activities, and maintenance of an adopted section of the Glacial Drumlin Trail.

Additionally, Restorative Justice Staff provided assistance to participants in locating and obtaining customized community service opportunities and accounted for 87% of the 2015's documented hours. With the array of options for participants to choose from, 918 total community service hours were performed.

Youth participants gained a valuable experience and expressed their feelings of completing community service with comments such as:

- "It's a great way to be a part of the community"
- "It was better to give than take away from community"
- "It's nice to help out and people appreciate it"

2015 Outcome Goals:

- 85% of all Community Service cases closed in 2015 will successfully complete their community service order.
    - Outcome: 85%

- Opportunities, Inc. will develop four additional community service events in 2015.
    - Outcome: 37

Restitution

The Restitution Program facilitates planning and implementations with youth to help ensure victims are compensated for monetary damage.

The restitution monitoring component of the Restorative Justice Program has been in place since 1996. In 2015, over $3,500 in restitution was collected and repaid to the victims of crimes in an effort to compensate them for monetary damages. The Restorative Justice Team assisted 19 participants in meeting their restitution obligations. Ten (53%) of the 19 participants of the Restitution program were categorized as ineligible for work, meaning they are 15 years of age or younger. Of those 10 participants, 2 made an initial payment towards meeting their obligations, with some cases still active. Of the 9 referrals eligible to work, 4 completed services in 2015; 3 successfully paying all restitution owed.

Individualized plans are developed with each participant to emphasize the importance of paying back victims and to ensure victims were fully restored. The Restorative Justice Specialists assist participants in locating jobs; however, with over half of the referrals being ineligible for employment, other creative options were implemented. Such options included completing extra chores at home and shoveling snow and mowing lawns for elderly neighbors.

Additionally, Opportunities, Inc. assisted 4 individuals with job development activities such as creating resumes and completing job applications and facilitated the development of job options with 13 youth. Opportunities, Inc. also directly provides work options for participants 16 years of age or older. In 2015, there were 5 Restorative Justice Program participants employed at Opportunities, Inc. that worked a total of over 890 hours and earned nearly $6,800.

2015 Outcome Goals:

- 75% of all Restitution cases eligible for work in 2015 will successfully complete their restitution order making the victim whole.
    - Outcome: 75%

- 75% of youth ineligible for work will have family pay toward restitution with youth providing a specific meaningful contribution to reimburse the family.
    - Outcome: 88%

Educational Program

First Offender Program

Using the evidenced based Aggression Replacement Training (ART) curriculum, this class teaches three main components that include Skill Streaming, Anger Management, and Moral Reasoning. Skills include but are not limited to: Beginning Social Skills, Advanced Social Skills, Skills for dealing with feelings, Skill Alternatives to Aggression, Skills for Dealing with Stress, and Planning Skills. Students also participate in moral reasoning discussion scenarios where students learn appropriate/mature ways of handling tough situations. Each class session is chosen specifically for the current participants, resulting in the class targeting certain learning skills that each participant can benefit from. The majority of the class time is devoted to role-playing, helping to keep the youth fully engaged.

2015 Outcome Goals:

- 70% of successful participants of the First Offenders program will not re-offend in the following 9 months.
    - Outcome: N/A. There were 14 preliminary youth referrals made to the First Offender program in 2015. Nine potential referrals that were deemed not ready for services in 2015 were carried-over for consideration into 2016. The other five youth did not participate due to issues such as scheduling constraints, service priorities, case expiration, and changes in referral appropriateness.

Victim Offender Conferencing

The Victim Offender Conferencing (VOC) program gives victims the opportunity to meet face to face with the youth to discuss the crime and why it happened. VOC has been available in Jefferson County since 1997 and the Restorative Justice Team continues to educate and encourage victims to participate in this process. VOC not only benefits the victim but is also restorative for the youth offender and the community as a whole.

The victims benefit from the meditation by being provided a chance to express their feelings about the event at hand, thus allowing the victims a voice. Youth offenders benefit from the mediation by being provided an opportunity to understand and make amends for the damage caused to the victims and/or the community at large. Finally, the community benefits from the mediation by repairing the harm done to the relationships affected by promoting nonviolent forms of conflict management, and potentially preventing the juvenile from offending again.

Options for incorporating the concepts of the Victim Offender Conferencing program are in three tiers. This is to ensure juvenile offenders have the opportunity to reflect on how their action affected others. The three tiers include:

- Using VOC as a diversion program.
- Incorporating VOC as a component of a Restorative Justice Plan.
- Requiring the youth to write an apology letter to the victim.

2015 Outcome Goals:

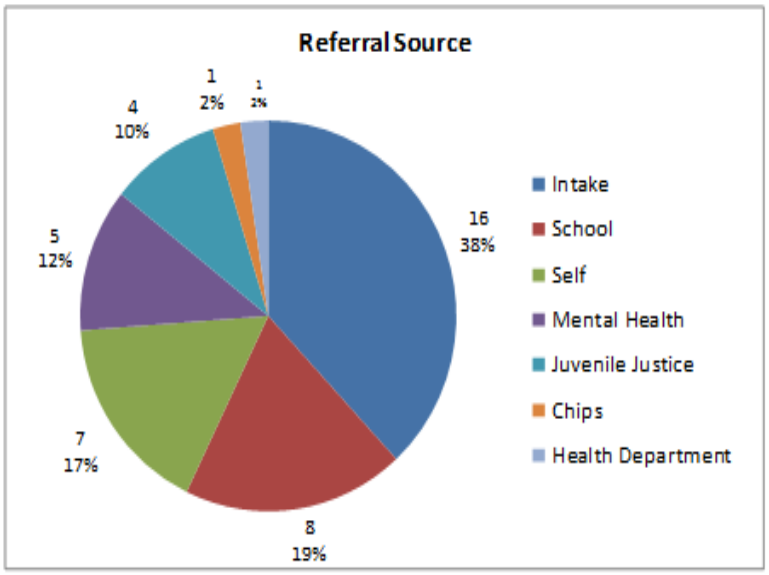
- The Restorative Justice Program will provide at least 6 Victim Offender Conferencing and/or apology letter sessions in 2015.
- Outcome: Three apology letters were completed in 2015. There were 13 preliminary youth referrals made to Victim Offender Conferencing in 2015. Five potential referrals that were deemed not ready for services in 2015 were carried-over for consideration into 2016. The other eight youth did not participate due to victim disinterest, service priorities, case expiration, and changes in referral appropriateness.

COORDINATED SERVICES TEAM/WRAPAROUND

"Keeping children with social, emotional, mental health and cognitive needs in their home."

Program Description and Updates

Jefferson County's Coordinated Services Team (CST) is an intervention and support model that offers participants a team-centered, strengths-based assessment and planning process. The vision of CST is to implement a practice change and system transformation. This occurs by developing a strengths-based system of care driven by a shared set of core values, which is reflected and measured the way CST providers interact and deliver supports and services to families involved in multiple systems of care such as child welfare, JJ, mental health, special education, and substance use. In 2015 CST provided case management services to 42 families. The pie chart to the right summarizes where referrals came from.



Jefferson County Hospice and CST/Wraparound Working Together

Jefferson County CST/Wraparound has seen an increase in referrals where the child has experienced the death of a parent or loved one such as a family member, friend or neighbor. We reached out to Rainbow Hospice of Jefferson County to see if they would offer a grief support group for children. Rainbow Hospice Care's bereavement counselor was more than willing to provide the "Forget Me Not" support group. The support group offered children opportunities and guidance to process their feelings in an age appropriate manner, while respecting the various individual circumstances. This group was developed for school aged children and allowed them to explore, share and grow with one another in a safe environment. We had three children attend the group.

Trauma Informed Care

In an effort to start bringing the community together to establish a shared language and knowledge base around child trauma, Jefferson County is participating in the Trauma Informed Care Initiative in collaboration with the Department of Children and Families. CST staff attended a TIC kickoff meeting on Thursday April 9th. Staff participated in one day of training on The Effects of Trauma on Children and Adolescents presented by the state trainer, Jennifer Wilgocki. One of the many techniques learned was the Invisible Suitcase activity and CST staff has implemented this activity to encourage team members to recognize where and why behavior challenges occur as it relates to childhood trauma. The CST staff also participated in a skill building workshop on March 24, 2015, focusing on TIC and how it relates to CST. This allowed staff an opportunity to share what strategies have been incorporated into Jefferson County's CST process with surrounding counties. We will continue to engage in TIC trainings internally through formal trainings and transfer of leaning activities led by our implementation team.

Motivational Interviewing

Motivational Interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. At Jefferson County all staff participated in year two of our Motivational Interviewing (MI) project , which included a series of onsite trainings refreshing our skills from year one, while enhancing our proficiency around the technical aspect of MI. In addition, staff members completed two audio recorded samples of using MI, which were then submitted to the trainers for coaching sessions so our skills could be rated and constructive feedback could be provided. In efforts to keep MI at the forefront of our practice as a team we conducted a number of transfer of learning activities. Our first activity was to modify the questions on the CST comprehensive assessment from closed questions to open ended questions. Staff felt by making this change they would be able to elicit pertinent information during the assessment phase of the process. This will allow for the care coordinator to elicit parent's responses giving them autonomy and authority, while allowing staff to sit as the learner in this conversational setting. This open dialogue will support the care coordinator with rating and targeting high need areas to develop person centered, outcome based goals. We will continue to participate in MI training booster sessions, learning labs and transfer of learning activities throughout the year to gain proficiency.

2015 SURVEY RESULTS

The CST project measures the efficiency of individual teams on team closure, family member closure, team effectiveness and family satisfaction via team surveys. Collecting this information will assist us with measuring the quality of practice for increased fidelity to the CST model and positive outcomes.

Team Member Closure Survey	Percent Somewhat Agree or Strongly Agree (N=10)
1. Team members were actively involved in the process	100%
2. Team members developed trusting & supportive relationships	100%
3. Team members were supportive of each other	100%
4. Our team developed a useful and comprehensive *plan of care*	100%
5. I am better aware of services available to this family	100%
6. Our team conducted regularly scheduled meetings	100%
7. Our team developed a *crisis response plan* we can rely on	89%
8. I have developed a positive working relationship with this family	100%
9. The family has the knowledge, skills and support necessary to continue making progress	78%
10. The family is more self-sufficient and able to advocate for themselves	78%

Testimonials

"Seeing people collaborate over the needs of one challenging child was inspiring and exciting."
"I was surprised with how professional, organized, motivated and caring the care coordinator was."
"I appreciated having a support system and a liaison with the family!"
"The care coordinator did an awesome job of planning and executing the details and follow-up work."

2015 Family Member Closure Survey	Percent Somewhat Agree or Strongly Agree (N=8)
1. Our Family was Treated with respect	95%
2. Our family developed trusting relationships with team members	84%
3. The team was supportive of our family	84%
4. Our family understands and uses the *plan of care*	89%
5. Our family has knowledge of the services we need or want	84%
6. Our family has access to the services it needs or wants	79%
7. Our team conducted regularly scheduled meetings	100%
8. We have a *safety (crisis)* plan we can rely on	74%

Testimonials

"Helped with getting needed help for our child especially getting the school assistance we needed."
"My daughter is doing extremely better since beginning Wraparound."
"We are actually closer to each other. Our family finally "became a family."
"Helped with getting the proper diagnosis so proper treatment could be provided."

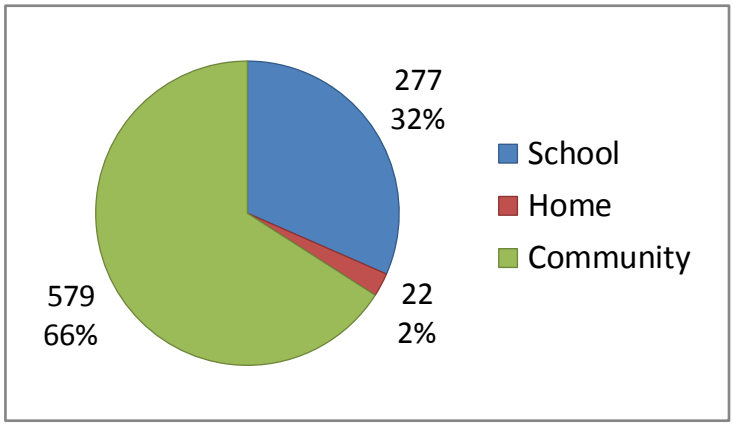
At the beginning of 2015, the Jefferson County Coordinated Services Team (CST) mailed satisfaction surveys to parents of active youth participants regarding their experience in 2014 with their CST. A total of thirteen parents returned the survey to a third party who recorded and analyzed the survey data. Parents were asked to respond to statements using a 5-point scale ranging from "Strongly Agree" to "Strongly Disagree". The percentage of parents who "Agree" or "Strongly Agree" (the top two points on the scale) with the following statements about the Jefferson County CST are presented below.

2014 FAMILY SATISFACTION SURVEY QUESTIONS ABOUT THEIR CHILD AND FAMILY TEAM	Percent Agree or Strongly Agree (n=13)
1. I feel that I am treated as an important member of my Child and Family Team.	100%
2. I am satisfied with the goals the Child and Family Team and I have set.	92%
3. The Child and Family Team take time to listen to my concerns.	92%
4. The Child and Family Team is respectful of my cultural background (race, religion, language, etc.).	100%
5. The Child and Family Team schedule meetings at times which are convenient for my family and me.	100%
6. I feel the Child and Family Team understands my child's strengths and needs.	92%
7. I know the Child and Family Team uses my child's strengths in setting goals and making plans.	100%
8. I would refer another family/child to the Coordinated Services Team Initiative.	100%
9. Overall, I am satisfied with the efforts of the Child and Family Team on my family's behalf.	100%
10. My care coordinator speaks up for my child and family.	100%
11. My family is getting better at coping with life and its daily challenges.	69%
12. If my child is 14 or older, the Child and Family Team has a plan to get the supports and services he/she will likely need when he/she turns 18.	83%

Community Outreach

Community Outreach is a service offered to CST families. Community Outreach provides 1:1 assistance to youth to help build the confidence they need to make positive pro-social strides, such as feeling good about themselves, making good decisions and staying positive. Other areas Community Outreach addresses is crisis intervention for schools and families, as well as short term respite for the parent or guardian. In 2015 Community Outreach worked on person centered planning with all youth involved in the program. For example if a young man wanted to be a Chef, community outreach would connect that youth with a local church for the use of their kitchen. This child would develop a grocery list, shop, prep and cook on a weekly basis working towards his desired goal. These activities are funded through Dodge/Jefferson and Walworth/Jefferson County United Way grants. The process of person centered planning has proven to increase the child's school attendance, behavior, academic achievement and relationships with teachers and peers. Furthermore, community outreach staff utilizes the curriculum 101 Ways to Teach Children Social Skills. This curriculum includes a variety of topics as well as activities which include, verbal communicating, nonverbal communication, being part of a group, expressing your feelings, caring about yourself and others, problem solving, standing up for yourself and managing conflict.

The local data at right, which is reported to the Department of Health Services, indicates that having a child work with a community outreach worker impacts the child in a number of positive ways. Through outreach, Jefferson County CST provided 579 community integration activities, 22 home visits, and 277 school visits. A wide range of goals are developed through the team process which utilize community outreach. One example that was developed with a young person was that community outreach will help the child with reading during their time together at school and in the community. After months of work, the following testimonial was provided by Heidi, Reading Interventionist at Cambridge Elementary School. "Look what Danielle did today! She read fluently and accurately at 82 words per minute... Third grade expectation is above 90 words per minute, but she did very well today on this progress-monitoring checkup :) My goal for her is set at the 25th percentile (84 wpm). Thank you for all your help."



Incredible Years Kids Group

The IY Kids group training series is a comprehensive video-based curriculum for use by staff that has experience working with small groups of young children with behavior challenges. The 2015 summer series consisted of twelve two-hour sessions within a 12 week timeframe, which took place in a community setting. The program emphasizes training in skills such as emotional literacy, empathy or perspective taking, positive communication skills, problem-solving strategies, anger management, and appropriate school behaviors. In general, the program promotes children's positive self-esteem and social and emotional competence. It is also important for addressing issues such as focusing, social isolation, internalizing problems, and social rejection. The intervention utilizes training and group methods that have been shown to be particularly effective for young children such as videotape modeling, coaching and reinforcement during structured practice activities, visual imagery, and live role plays. Staff provides transportation, snacks and meals, eliminating any barriers to attendance. CST service facilitators taught the class so transfer of learning activities can occur through the team process when developing the plan of care so children can be supported and guided in all environments. The 2015 group consisted of seven children ranging in ages from 6-10.

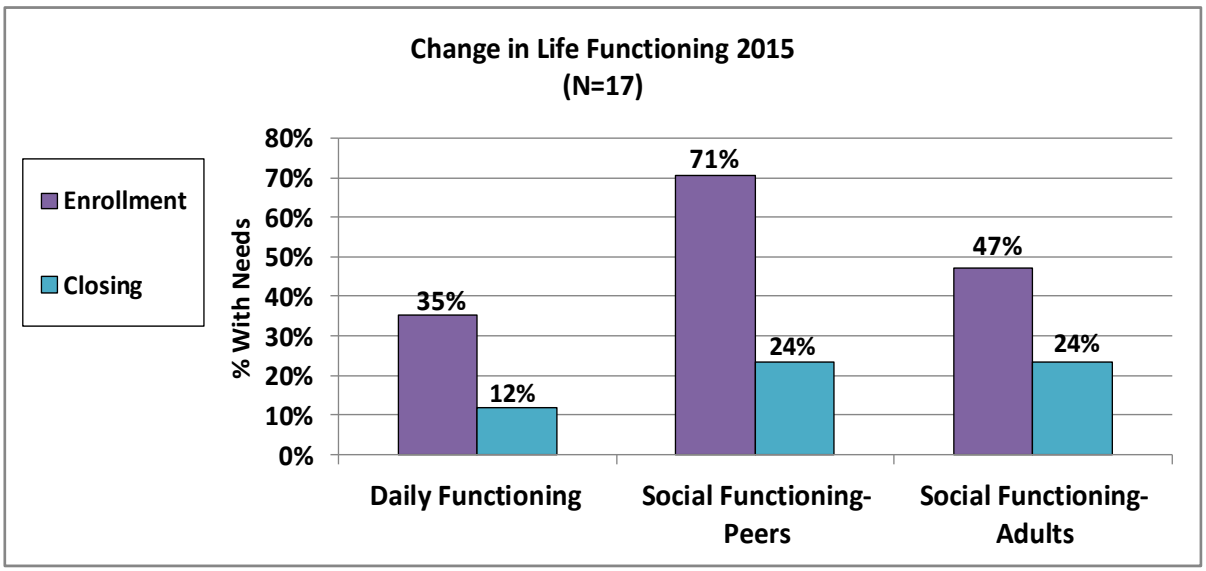
Targeted Case Management

Targeted Case Management (TCM) is a child centered, family driven and community based service that can be billed through Wisconsin Medicaid. Projected revenue for 2015 was $30,000.00 with actual revenue being a robust $63,203.00. This dramatic increase in revenue was in part related to DHS allocation which added a fulltime service coordinator that was able to bill TCM. More importantly, the department developed and utilized extensive auditing tools for ongoing monitoring of assessment and planning efforts to maximize targeted case management and increase compliance with Medicaid.

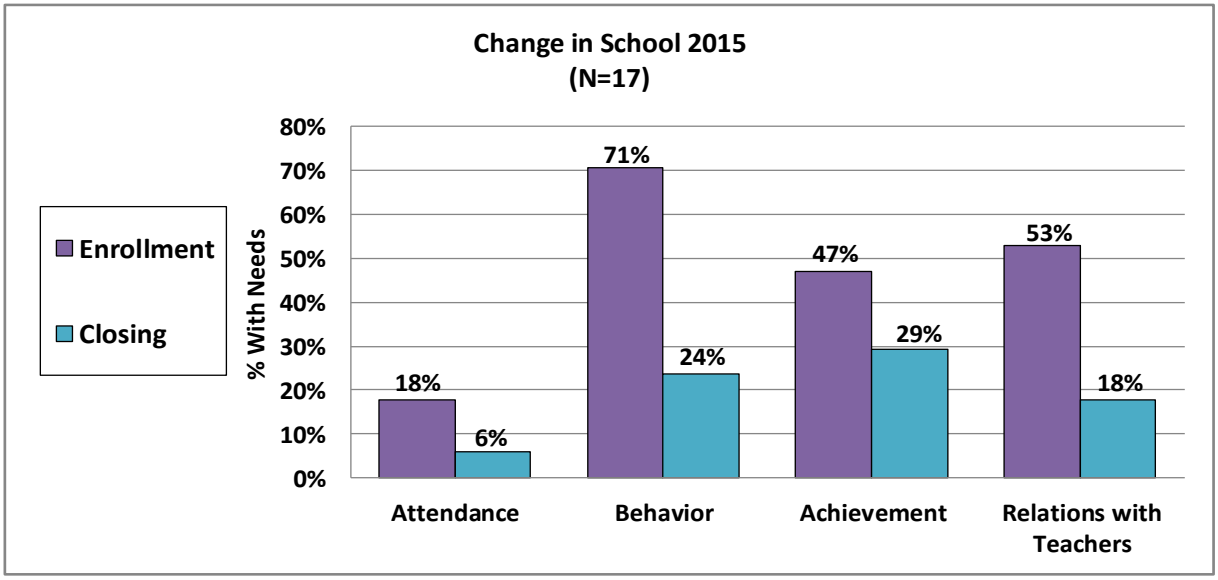
CANS Youth and Caregiver Assessment Ratings

Youth and families that are enrolled in the CST are assessed using a comprehensive tool called the Child and Adolescent Needs and Strengths (CANS) tool. This data is reported to the Department of Health Services at enrollment and disenrollment to monitor their progress as to the severity of their needs. Youth and families are rated on a 4 - point scale with 0 - no need, 1 – need to watch prevent, 2 - plan is needed, 3 – plan is needed now (crisis). Data was collected from 17 families that were disenrolled in 2015.

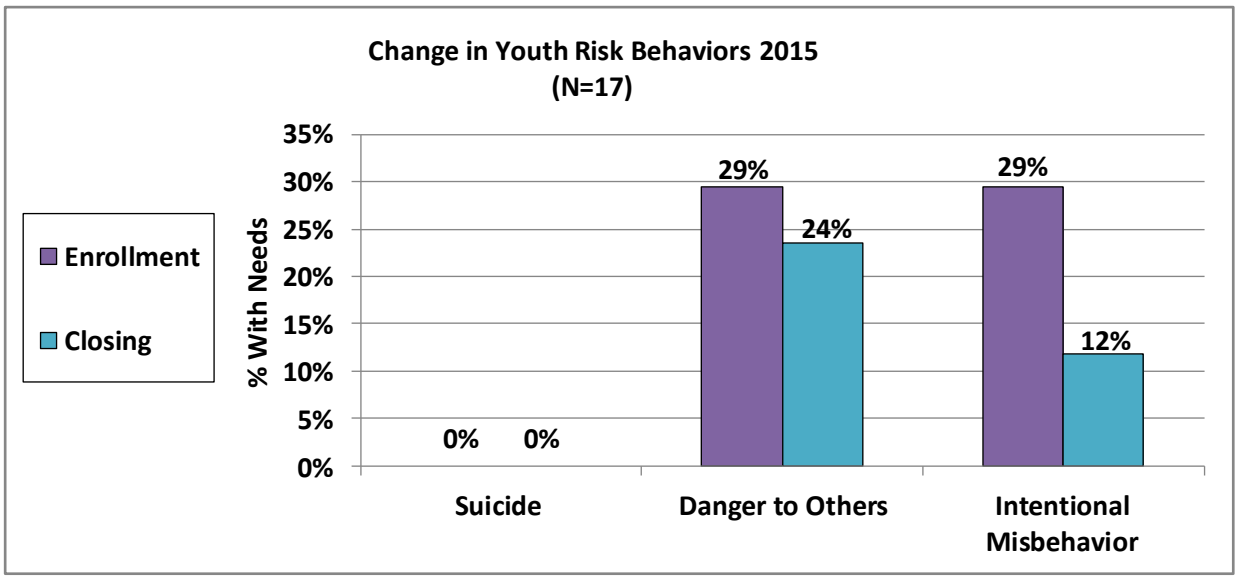
Data reflects that CST youth improved in the area of age appropriate self-care skills and increased their independence. They have also shown significant improvement in relationships with their peers and adults, which were able to be maintained for an extended period of time.



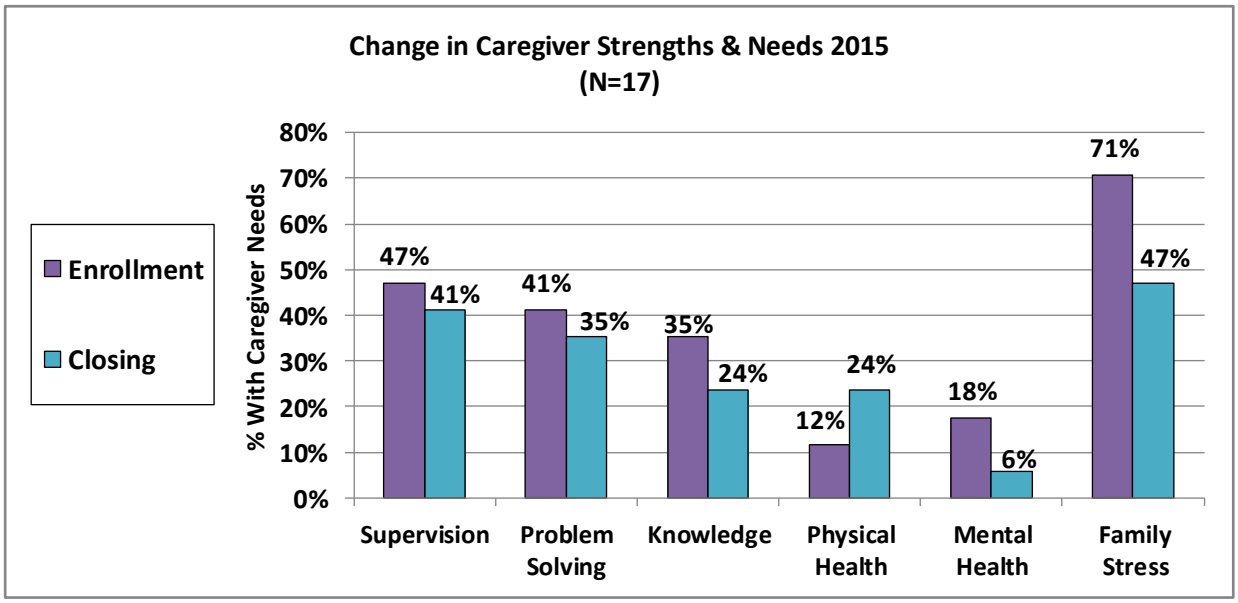
Youth are also rated on important areas of school functioning such as school attendance, behavior, school grades and developing positive relationships with teachers. All areas improved for youth disenrolled in 2015.



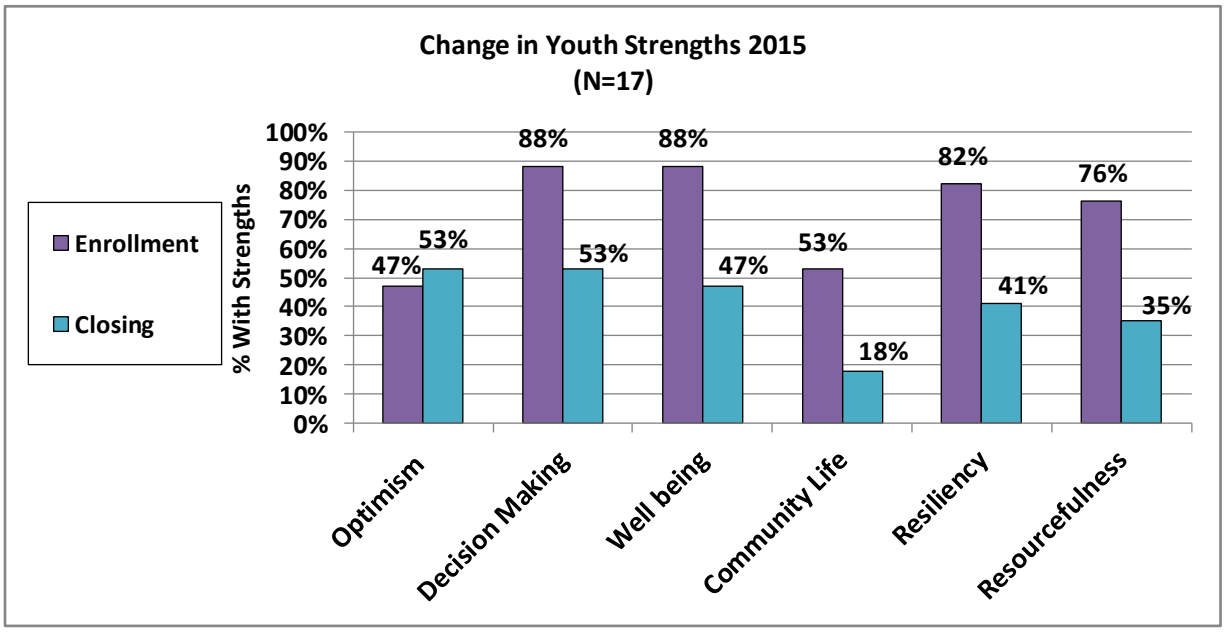
At enrollment and disenrollment data shows no evidence of suicide ideation, but a decrease in aggressive behavior and intentional misbehavior. CST assists youth with developing coping and problem solving skills so they can independently maintain control. Intentional misbehavior is defined as problematic social behaviors.

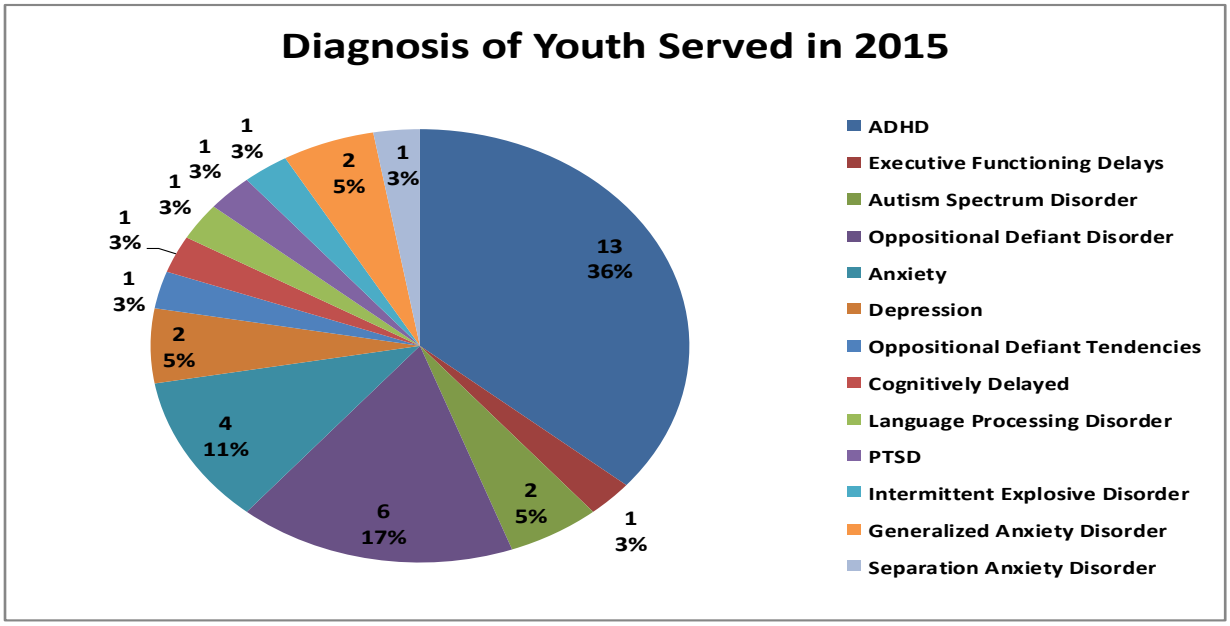


At enrollment the higher the percentage shows a higher need and the decrease in the percentage shows there was improvement with the caregiver strengths. At disenrollment data shows the level of needs for youths' caregivers improved in a number of areas including supervision, problem solving, and knowledge of the child's diagnosis, mental health and family stress. Providing CST services and resources to the caregiver assisted the caregiver with meeting the care needs of their child and overall family satisfaction and strife.



Finally, youth strengths are also assessed to determine ability to cope with their behavioral health needs. Again, at enrollment the higher the percentage shows a higher need and the decrease in the percentage at discharge demonstrates the improvement. Between enrollment and disenrollment, the CST work with youth to help increase the array of strengths youth possess such as having a positive outlook, making better decisions, getting involved in community activities (Scouts, YMCA, Libraries, Youth Centers) individual talents (music, art, sports), peer relationships, and the resiliency to deal with adversity.





Review of 2015 Goals:

1. **The Key Outcome Indicator for the Coordinated Services Team (CST) in 2015 was that 90% of all children will remain in the home.** CST provided services to 41 children in 2015. Data shows 95.2% (39 out of 41) children served via the CST process successfully remained in the home.

2. Through the utilization of the State Legislative checklist, Jefferson County CST will adhere to the statutory provisions established by the Legislature in Wisconsin Statue 46.56 as evidenced by the coordinating committee reviewing the check list. The coordinating committee will identify deficits that need to be addressed and develop a plan on meeting the statutory provision contained in the checklist within the 2015 year as evidenced by 100% completion of the checklist. ***This goal was accomplished***. *At the October 2015 coordinating committee meeting, members reviewed the State Legislative checklist as a self-assessment to meeting the statutory provisions. A number of deficits were found including the need to have a training plan for coordinating committee members and the various members of the coordinated services team members*

as to the coordinated services team approach. Additionally, it was discovered that the committee needed to distribute information to the public about the availability of the CST initiative, including public and private providers. Subsequently, a plan was developed to address the deficits within the year. Furthermore, members identified the need to be educated on resources and services that can be offered to families and therefore training for the committee, as well as for the community, was developed and conducted as part of the legislative checklist.

3. Provide a county wide training and resource fair to develop a community of practice by bringing family members, school personnel, and providers together to build an understanding regarding preventative services available to families throughout Jefferson County. ***This goal was accomplished***. *Jefferson County CST hosted county wide training in May of 2015 for schools, police departments, Work Force Development staff, families, Human Services staff and local providers. Ann Kellye Kuemichel from Milwaukee County Coordinated Services presented on: What is CST/Wraparound? What's needed for the approach to work? Values in action – Family centered youth guided collaborations and system integration. All attendees received a copy of Jefferson County's Resource Guide for Families and Caregivers for Children with Special Needs and Mental Health Challenges. The feedback from the training surveys were all excellent and the community left the training with an increased understanding of the CST process.*

4. Re-evaluate the Team Effectiveness, Family Satisfaction and Team Closure surveys by consulting with an outside evaluator to obtain feedback on the validity and effectiveness of the survey, so the CST program can maximize survey results to make needed program changes for improved outcomes. ***This goal has been partially accomplished***. *Surveys were presented to the Coordinating Committee for review and feedback. Suggestions and feedback from committee members ranged from, "Survey results could be skewed by having the Wraparound coordinator in the room the same time as the members that are filling out the surveys", and "surveys could benefit from changes to linguistics, some of the wording may be confusing for recipients, and rating scales could be modified." The next step will be to find an outside consultant to review the recommended survey concerns.*

5. Coordinated Services Team staff will be trained in developing connectedness maps, genograms and mobility maps so family teams can develop a shared understanding of the family dynamics and history as evidenced by completion of the tools as well as completion of the goal identified on the plan of care. ***This goal was accomplished***. *In August a State Permanency Consultant from the Department of Children and Families presented to Jefferson County Coordinated Services and Children's Long Term Support staff. The Connectedness Map is a technique service facilitators can utilize to clarify the connections or lack of connections of a child by showing family members and others connected to the child. Service Coordinators can use this tool to assist the family with discovering and or identifying natural supports to join the team process to which the child feels connected to. Mobility mapping is a child's memory of his or her life put on paper. The process can reveal a child's daily activities and significant relationships, as well as distinctive community or neighborhood features, structures, or geographic characteristics. This information can reveal to teams the child's story about where they came from and important emotional connections from their past.*

2016 Goals:

1. **Key Outcome Indicator: 90% of all children will remain in their home with the use of CST services.**

2. Increase natural supports on teams from 75% to 85% by using a format such as connectedness and/or mobility mapping when families are struggling to identify natural support participation.

3. Reevaluate all CST surveys through an outside evaluator to obtain objective feedback on appropriateness of survey composition, language and intent. The goal is to ask precise questions for accuracy of collecting information so we can maximize survey results to make needed program changes for improved outcomes.

4. Provide a county wide training to educate internal and external providers on the roles and responsibilities of the service facilitator and the principles of Wraparound so team members have an increased understanding and knowledge of "What Wraparound is" and "What Wraparound is not" by 12/31/16.

5. Create a parent to parent learning system (support group) that harnesses parent's areas of expertise for supporting and educating each other by 12/31/16.

BIRTH TO THREE PROGRAM

"Supporting Families in Promoting the Growth and Development of Their Children"

The Jefferson County Birth to Three Program is committed to empowering families who have young children with developmental delays or disabilities by enhancing their ability to promote their children's growth and development. Recognizing parents as the primary influence in their child's life, the Birth to Three program employs the parent-coaching approach to services. Rather than professionals working directly with the child, the coaching model provides support to the parents in improving their child's skills and abilities.

In a continuous effort to provide effective and meaningful programming, the Jefferson County Birth to Three aligns practices and professional development with county and state initiatives. Supporting family mental health is the focus of two county initiatives: Motivational Interviewing (MI) and Trauma-Informed Care. Participating in the agency-wide MI training initiative has provided staff with the opportunity to cultivate skills that are essential to Birth to Three programming. Motivational Interviewing is designed to promote engagement through conversations and evoke motivation to make positive changes. Parent engagement and active participation in Birth to Three programming is crucial for supporting progress towards family outcomes.

Professional development activities offered to county employees through the Trauma-Informed Care initiative has increased awareness of the effects of trauma on children and families. Recognizing and understanding trauma has strengthened the Birth to Three staffs' ability to engage families who have experienced traumatic events. The Birth to Three Team has been able to provide responsive and intentional service for families who have been affected by traumatic events.

The Birth to Three Mission Statement

The Birth to Three Program is committed to children under the age of three with developmental delays and their families. We value the family's primary relationship with their child and work to enhance the child's development and support the family's knowledge, skills and abilities as they interact with and raise their child.

- "The Birth to Three Program made a tremendous difference for our family. Our daughter's speech delay was completely resolved in our time with the program."--CR

The Wisconsin Birth to Three State Systemic Improvement Plan (SSIP) identifies positive social and emotional development as crucial to increasing positive outcomes for children and families. The SSIP has triggered the planning of state-wide systems change and professional development. During the fall of 2014, state Birth to Three representatives participated in a workgroup that recognized implementation of the Pyramid Model for Social and Emotional Competence as a priority for improving outcomes for infants and toddlers. In 2015, Birth to Three staff made it a priority to join the Wisconsin Alliance for Infant Mental Health (WiAIMH). Membership provides many professional development opportunities centered on the awareness and understanding of infant, toddler and family mental.

In November of 2015, the Jefferson County Birth to Three Program was awarded a grant to support the implementation of Parents Interacting With Infants (PIWI) playgroups by the Pyramid Model leadership team.

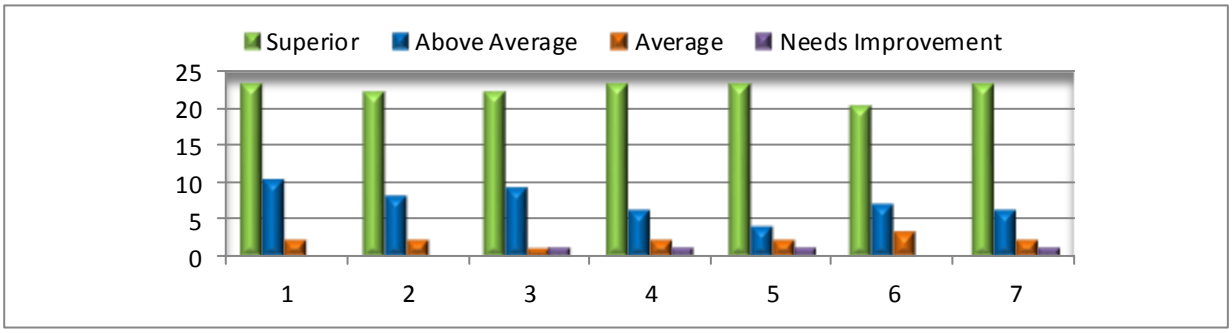
To better understand the effectiveness and supportiveness of the services provided to infants, toddlers and families through the Jefferson County Birth to Three Program, feedback is requested from families in the Family Exit Survey. Each family receives the survey at their child's discharge meeting. Families are encouraged to complete the survey and return them by mail.

The PIWI playgroup model reinforces the social and emotional development of children by strengthening the parent child relationship. Playgroups will be held in summer and fall of 2016.

2015 Jefferson County Birth to Three Family Survey Items and Results

1. Our Birth to Three team explained that the program focuses on helping families be able to strengthen their child's abilities within their everyday routines at home.
2. Our team helped us understand our child's abilities and development.
3. Our team helped my family develop outcomes (goals) that were important for my child and family to work toward.
4. Birth to Three services have helped us be able to communicate our child's needs to others.
5. Our Birth to Three Team helped my family through the transition process.
6. Did you receive timely follow-up to questions, concerns or phone calls?
7. Overall, how happy are you with the services and support you received through the Birth to Three Program?

In 2015, the Birth to Three Program contacted 365 families. We also had 132 families that were continuing existing services and 233 families were new referrals to the program.



Birth to Three Federal Indicators

Indicator 1: Timely Services
Indicator 2: Natural Environments
Indicator 3: Child Outcomes
Indicator 4: Family Outcomes
Indicators 5 and 6: Child Find
Indicator 7: Timely IFSPs
Indicator 8: Timely Transition

The Birth to Three Indicators have been identified by the federal government as the essential components for implementing high-quality, early intervention programming. The state tracks data related to the eight Birth to Three Indicators to monitor compliancy. The Indicators' focuses are the identification of potential eligible children and the program effectiveness based on timely and meaningful services that enhance child and family outcomes.

2015 Child Find
Fort Atkinson Child Share and Care Fair
Watertown Children's Community Fair
Johnson Creek Child Safety Fair
Ready Kids for School
Parent Cafes
Jefferson Public Library

"This was my first experience with Birth to Three and it was great. Everyone was so helpful and full of information. Thanks for everything!"

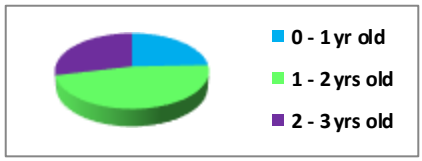
—Kate

Indicator 5 & 6: Child Find

The Jefferson County Birth to Three continually searches for opportunities to identify infants and toddlers who are potentially eligible for services. To ensure programming is accessible to the young children and families living in the county, Birth to Three staff participate in community events and collaborative activities to increase awareness of the program. Literature is also provided to organizations that offer family services.

Anyone who has concerns about the development of a child birth to three years of age living in Jefferson County may contact the program to make a referral.

Ages at time of referral



Referral Source	Percentages
Primary Health Care Providers	44%
Parent	25%
Social Services Agency	20%
Hospitals or Specialty Clinics	5%
Other	4%

Indicators: 1, 7 and 8: Timely Services

Indicators 1, 7 and 8 are considered compliancy indicators. The compliancy indicators are indicative of the timeliness in which families receive services. County programs are accountable for ensuring 100% of the services outlined in the indicators are received within the timeframes outlined by state regulation.

The Jefferson County Birth to Three Program was recognized for reaching 100% compliancy with Federal Indicators in 2015!

Compliancy is reached by ensuring that the following areas of service are facilitated in a timely manner:

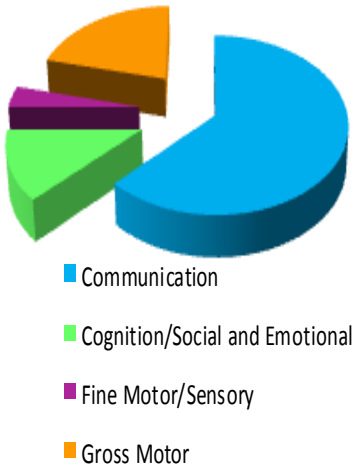
Responses to referrals

The Birth to Three process begins with the service coordinator contacting the family of the referred child to explain what can be expected during the Birth to Three process. The Service Coordinator provides an overview of the program, discusses the referral information that was provided and explains the program's mandated timelines and parental rights.

In 2015, a screening procedure was put in place to give families the opportunity to learn about their child's development prior to starting the referral process.

Part of the referral process is a discussion of the developmental screening information provided by the medical provider as part of the referral or collected during the family's initial visit. Understanding their child's development in relation to the screening information helps parents make an informed decision when determining if they are interested in pursuing the referral.

Areas of Concerns at Referral



"Birth to Three was the best thing to happen for our son and our whole family! All the staff was friendly, informative and always so helpful. We will miss the program immensely."

Assessment and Evaluations

Birth to Three evaluations provide a global view of a child's development. Through the evaluation process, parents learn about their child's development in the following areas:

- Problem solving
- Understanding and expressing ideas
- Self-help skills
- Ability to move around their environment
- Expressing feelings and emotion

Evaluation information is collected through parent interviews, observations of the child, and play-based, standardized evaluation tools. The Birth to Three Team creates a developmental summary from the collected information to share with the family. The summary guides the discussion regarding the child's eligibility for services.

Eligibility determination in 2015

Children are determined eligible for Birth to Three services based on one of three possible criteria:

- Significant delay in any area of development
- Atypical behaviors that are negatively impacting development
- A diagnosed condition likely to result in developmental delays

Individualized Family Service Plan (IFSP)

In 2015, the new state developed IFSP plan was fully incorporated into programming. The IFSP is designed to encourage more parent participation in their child's Birth to Three services.

After a child is determined eligible, the IFSP is developed together by the family and Birth to Three Team. The child's present levels of development, family strengths, concerns and resources, along with the expected outcomes for the child are documented in the IFSP. The service plan for the child and family is also outlined in the IFSP document. The document is reviewed at least every six months or whenever there is a change in services.

Services	# of children
Education	88
Speech	196
Occupational Therapy	52
Physical Therapy	77

2015 Service Locations
Family Businesses
Supervised Visitations
Parks
Restaurants
Play groups
Library
Laundry Mats
Child Care
Foster Homes
Relative's Homes

"The team was amazing. Answered all questions timely and thoroughly."—Krystin

Services are designed to support parents in promoting the growth and development of their child during their everyday routines and to enhance the families' ability to fully participate in their community. During home visits, parents are coached in ways to foster their child's developmental progress toward the outcomes the family identified as important in their IFSP. Parents are then able to use these techniques and strategies to build meaningful learning experiences into their child's everyday routines.

In 2015, Family Communication Folders were developed and distributed. The folders enhance parents' ability to promote their child's growth and development throughout their daily routines.

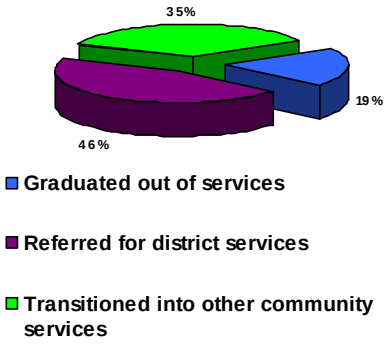
Birth to Three services also focus on family wellbeing. Service coordinators understand the needs and priorities of the families they work with through frequent phone calls and visits. When assistance can be provided through community support, service coordinators help families connect with programming.

Community supports service coordinators have worked with:

Medical Providers	Food Pantries	Autism Treatment	Medical Assistance
Transportation	Playgroups	Parent Education	Assistive Technology
Counseling	Head Start	Energy Assistance	Medical Specialist

Transition Planning

Most children continue Birth to Three services until they are no longer in need of services or until they turn three years of age. All children exiting services receive transition planning to support moving into their next stages of early childhood. Early childhood transition options include school district programming, Head Start, child care, play groups or other appropriate community services.

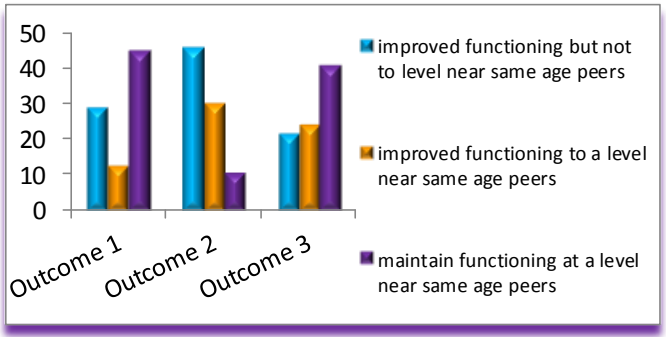


In 2015, Birth to Three hosted an Interagency Agreement Meeting inviting local school districts and Head Start to discuss transition practices. The transition process was reviewed to ensure smooth transitions for all families.

"I loved Birth to Three. They helped me work with my child and she loved when they were here."—Amanda

Indicator 3: Child Outcomes

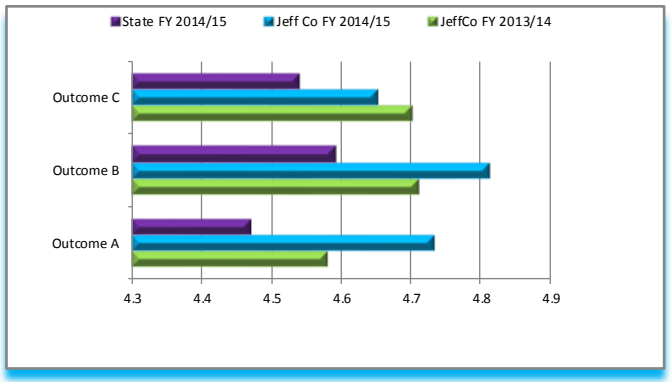
Birth to Three programs are charged with showing the developmental progress of children from the beginning of programming to discharge. Through the initial evaluation process and ongoing assessment, Birth to Three teams track a child's progress towards growth in three areas:



Outcome 1: Positive social-emotional skills
Outcome 2: Acquisition of knowledge and skills
Outcome 3: Taking appropriate action to meet needs

Indicator 4: Family Outcomes

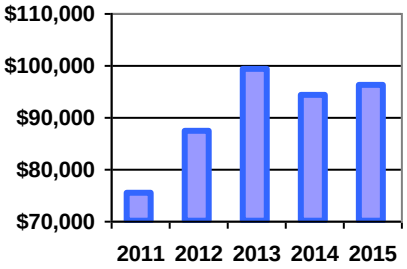
The effectiveness of programming in relation to family outcomes is measured by the state-distributed Wisconsin Family Outcomes Survey. Families are asked to report on how participating in programing supported them in the three outcome areas.



Outcome A: Knowing their rights
Outcome B: Effectively communicating their child's needs
Outcome C: Helping their child develop and learn

Reimbursement for services

Birth to Three programs are funded through a variety of sources. The federal government, state of Wisconsin and Jefferson County provide funding to support programing. Families are asked to provide information so that Birth to Three can bill their insurance companies for reimbursement for services. Birth to Three service coordination is eligible reimbursement through Wisconsin Medical Assistance (MA) Program as Targeted Case Management.



In 2015, the program was reimbursed for the eligible service coordination activities of 118 families by MA. The county was able to bill MA for over $96,000 in services.

"Thank you so much for <u>everything</u>!!"--HR

Wisconsin also requires county programs to implement a Parental Cost Share System. Parents who are determined able financially to share in the cost of their child's services are assessed a monthly cost share rate. The rate is determined by the state and is based on family size and income.

The 2015 Parental Cost Share System collected $8,464.00, which was used towards the cost of services provided to the families who participated in the system.

Review of 2015 Goals:

1. **The Key Outcome Indicator in 2015 was that the Birth to Three Program will be issued a notification of 100% compliance with the Federal Compliancy Indicators by DHS based on the annual data review.** The Jefferson County Birth to Three Program was issued a notification of 100% compliance to the Federal Compliancy Indicators for 2015.

2. The Birth to Three Program will successfully implement a colleague to colleague coaching approach to teaming in accordance with the Primary Coach Approach model of services. Successful implementation will be facilitated through the use of the team meeting guidelines identified as best practices by state leadership. ***This goal was accomplished***. *In 2015, the Jefferson County Birth to Three Program fully implemented a colleague to colleague approach to teaming. Staff are now divided into three regional Early Intervention teams. Each team consists of a service coordinator, educator, speech pathologist, physical therapist and an occupational therapist. Colleague to colleague teaming has been enhanced by having the service coordinators facilitate their team's meeting. Teaming agendas include opportunities to ask for colleague support in challenging situations. Teams also support each other by discussing progress, goals and the appropriateness of service changes during team meetings.*

3. The Birth to Three Program will increase revenue for targeted case management (TCM) by 10% to ensure sustainability of the colleague to colleague coaching approach to teaming. ***This goal was accomplished***. *When considering the increase in the total amount of TCM billed for reimbursement in 2015 and the significant decline in services that were eligible for reimbursement from 2014 to 2015, the increased efficiency of TCM billing is equivalent to a 10% increase in revenue. A decline in the number of families using Medical Assistance caused a 13% deficit in billable services in 2015 compared to 2014. The Birth to Three Program was able to compensate for the 13% deficit and increase the total amount of revenue generated by TCM by 2%.*

4. The Birth to Three Program will develop a community outreach activity dedicated to enhancing parents and caregivers capacity to meaningfully engage with the children in their care. The needs and interests of the early childhood community and caregivers will guide activity development. ***This goal was accomplished***. *During the summer of 2015, the Jefferson County Birth to Three Program hosted a three session pilot of the Parents Interacting with Infants (PIWI) playgroup. The PIWI playgroup is an evidence-based model focusing on the parent-child relationship. The model provides guidelines for supporting a caregiver's competence, confidence and mutual enjoyment of his or her child. In November of 2015, the Wisconsin Pyramid Model Leadership Team and the Wisconsin Alliance for Infant Mental Health awarded the Jefferson County Birth to Three Program a PIWI implementation grant. The grant will allow for two 6 session PIWI playgroups to be run in 2016.*

5. The Birth to Three Program will increase community awareness through the development and distribution of informative reading materials that highlight the program's mission and access points. ***This goal was accomplished***. *Much of the programs written media was reviewed for the need to be updated in 2015. The program brochures contact information needed to be updated. An electronic version of the brochure, which included pictures with copy write permissions, could not be located. To address the issue, stickers were printed to place over the incorrect information on the stock of printed brochures. The program is in the process of collecting pictures of children and families, with permission, for multimedia use, to build a new brochure. The informational presentation that is displayed on the Human Service's lobby television was updated. It was reformatted and rescripted to be inviting and reader friendly.*

During 2015, the Birth to Three program increased community awareness by distributing media through family outreach events. Brochures and business cards were distributed at the early childhood screening days. Staff where at the Watertown Children's Community Fair, the Fort Atkinson Child Share and Care Fair, the Johnson Creek Child Safety Fair and the Ready Kids for School event with an information booth. Information was also presented and distributed during a meeting of the Jefferson County Childcare Director's Group.

6. The Birth to Three Program will ensure families are able to make educated decisions regarding insurance access and the Parent Cost Share system by developing a procedure that provides a detailed explanation of benefits and cost share prior to receiving services. ***This goal was accomplished***. *An informative letter outlining the program's procedure for determining eligibility and billing families under the state-mandated Parent Cost Share System has been drafted. The letter is mailed to families who qualify for a Cost Share after their child's eligibility has been established and an Individualized Family Service Plan is in place.*

2016 Goals:

1. **Key Outcome Indictor: The Birth to Three Program will be issued a notification of 100% compliance with the Federal Compliancy Indicators by DHS based on the annual data review.**

2. The Birth to Three Program will build on current practices for transitioning children into the school district setting to ensure parents exit programming with the capacity to confidently advocate for their child's needs, effectively engage in their child's school setting and foster positive learning experiences for their child.

3. The Birth to Three Program will provide two opportunities within the community that promote meaningful dyadic relationships between parent and child by implementing the Parent Interacting With Infants (PIWI) model of playgroups through the support of the PIWI implementation grant award to the program in November of 2015.

4. In 2016, the Birth to Three Program will ensure that programming continues to be meaningful, effective and efficient by completing at least one project and two program improvement projects. The program improvement projects will be based on parent feedback and reflective practices of staff.

5. To ensure effective implementation of Motivation Interviewing (MI) practices, the Birth to Three staff will continue to participate in professional development opportunities provided through the MI initiative.

6. The Birth to Three Program will continue to streamline billing for Targeted Case Management by identifying missed opportunities for reimbursement and putting measures in place to capture that revenue in 2016**.**

BUSY BEES PRESCHOOL

~Providing positive early learning experiences in a fun-filled morning ~

Busy Bees Preschool offers positive learning experiences for two and three year old children. Preschool runs two mornings a week for two and a half hours. Busy Bees provides regular preschool programming from September through May.

The preschool class is a combination of children invited to enroll through the Jefferson County Birth to Three Program and children from the community. Up to seven community children attend preschool programming two days a week. Up to 12 children receiving Birth to Three services are in enrolled at one time. These children come to preschool one day a week.

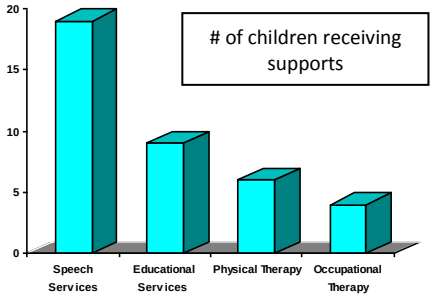
During the 2015-2016 school year, the preschool enrolled 20 children receiving Birth to Three services and eight children from the community.

The Busy Bee's preschool's philosophy recognizes that strong relationships between the teacher, the child and the family are the foundation for enhancing development. Families are encouraged to participate in their child's learning experience through daily communication, observation opportunities, and family projects.
A daily note is sent home with children letting parents know what their child did during free play, ate for snack and created for art. An observation window enables parents to watch their child engage in classroom activities during preschool. Parent/teacher conferences occur twice a year providing time for teachers and parents to discuss the child's learning experiences and developmental progress.

Busy Bees Preschool offers fun-filled, enriching mornings with structured routines and consistent behavior expectations. The unique abilities of the preschoolers are celebrated through rich learning experiences that build on their skills. The support of teachers who understand how to promote learning through open-ended questions, guidance and scaffolding fosters growth and development. Children increase their social-skills, self-esteem and overall confidence by participating at preschool.

Classroom activities emphasize language and concept development through free play, music, finger plays, books, gross and fine motor activities, art experiences and daily living skills, including a snack time and bathroom routine. Lesson plans address all domains of learning with developmental appropriate practices. Wisconsin Model Early Learning Standards serve as a guide when planning learning experiences.

The preschool is staffed by three full-time educators with over 30 years of combined experience working with young children. All of the preschool teachers hold Wisconsin Teaching Licenses. The teachers are also part of the Wisconsin Registry for Educators. In addition licensed speech therapists, an occupational therapist, and a physical therapist provide support in the classroom as part of Birth to Three programming.



State Licensing for Child Care

The preschool was issued a statement of no, non-compliances after the 2015 licensing inspection.

Busy Bees Preschool is licensed as a childcare program through the Wisconsin Department of Children and Families. Licensing requirements ensure the health, safety and well-being of children in childcare. Regular on-site inspections are conducted to monitor compliancy with requirements.

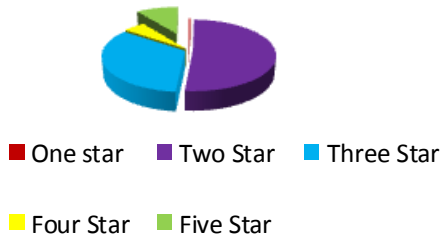
YoungStar Participation

Busy Bee's Preschool received a $1000 grant for participating in the YoungStar program. The grant supplemented funds for professional development activities in 2015.

The Department of Children and Families has adopted YoungStar as Wisconsin's child care quality and rating and improvement system. The rating process includes a review of employees' qualifications, the learning environment, business practices and wellness practices. Technical assistance is provided to support programs in identifying opportunities for quality improvement. The program is then observed by a formal rater to complete the process. Programs have the opportunity to be awarded up to 40 quality indicator points from the rating and observation process. The amount indicator points earn dictate the number of stars the program is awarded.

What the stars mean	
5 Star	Meets highest levels of quality standards
4 Star	Meets elevated levels of quality standards
3 Star	Meets proficient levels of quality standards
2 Star	Meets health and safety standards
1 Star	Does not meet standards

Summary of YoungStar rating results for child care rated across Wisconsin.
Updated 2/16



Busy Bee's Preschool was rated as a five star program in 2015!

Review 2015 Goals:

1. **The Key Outcome Indicator in 2015 was that the Busy Bees Pre-School will maintain a 4 star rating from the YoungStar Program.** The Busy Bees Preschool Program received a rating of 5 stars from the YoungStar Program in 2015.

2. The Busy Bees Preschool will complete the YoungStar process and maintain or improve its 4 star rating. Ratings are determined through the Wisconsin Child Care Rating Program based on points earned in four categories: education, learning environments and curriculum, professional and business practices, and child health and well-being practices. ***This goal was accomplished****. The Busy Bee's Preschool was awarded a 5 star rating upon completion of the YoungStar rating process in 2015.*

3. The Busy Bees Preschool will increase parent engagement by developing additional programming to educate parents about their child's growth and development. ***This goal was accomplished****. Busy Bees Preschool hosted a three session pilot of the Parents Interacting with Infants (PIWI) playgroups. The evidence-based model focuses on enhancing the parent-child relationship through facilitator guided discussion and play activities that encourage parents to engage with and learn about their child. The guidelines for the model are designed to support the caregiver's competence, confidence and mutual enjoyment of his or her child.*

4. The Busy Bees Preschool will ensure access to all families in the Birth to Three Program with a child whose development would be enhanced by participating in the preschool by developing an enrollment protocol. ***This goal was accomplished***. *Busy Bee's enrollment protocol now includes considering each child in the Birth to Three Program who would be age appropriate for the preschool. Considerations include abilities and needs, parental interests, capacity to get to school, follow through with Birth to Three services and the appropriateness of the preschool setting for the child. The considerations are initially staffed by the supervisor and service coordinators. After a list of potential children is developed, the placement considerations are then staffed by the Early Intervention Team.*

5. The Busy Bees Preschool will participate in activities that enhance support for the local early childhood community. ***This goal was accomplished***. *The technical assistant time offered through YoungStar was designed to provide support in developing a childcare directors group in 2014. The Jefferson County Directors' Group has been meeting monthly since June of 2015. Attendance has been averaging 8 to 12 directors a month. The group has identified several areas of interest for training and discussion topics. The state licensor has presented to the group. The group has provided support on local family resources, staffing and hiring concerns, YoungStar ratings and much more.*

2016 GOALS:

1. **Key Outcome Indicator**: **Busy Bees Pre-School will maintain a 4-star rating from the YoungStar Program.**

2. Parent engagement will be enhanced through professional development opportunities and implementation of parent engagement strategies provided during the YoungStar technical assistance process.

3. The preschoolers' social and emotional development will be enriched through parent education and opportunities to participate in activities that promote the parent-child relationship.

CHILD ALTERNATE CARE

"Alternate Care services were developed to provide for the physical, emotional, and social needs of the child until the child can be reunited with his or her family."

The child alternate care team provides services for the residents of Jefferson County which includes licensing Kinship, level 1 and level 2 homes, as well as locating placements at all levels of care to include foster care, group homes, CCI's and juvenile corrections. Pro-actively, staff cultivates and locates respite care and facilitates voluntary placements throughout the year. In 2015, we continued monthly foster parent support groups, as well as the annual foster care appreciation dinner, which corresponded with National Foster Parent appreciation month in May. In 2015, Jefferson County continued to locate and build stabilization services to avoid long term and highly restrictive placements. Our foster care coordinator expanded our contracts with local agencies to develop crisis beds with foster homes to avoid unneeded and lengthy placements at institutions and hospitals. Through training, psycho-education and collaborative crisis planning, these crisis beds were utilized and hospitalizations decreased in 2015. Child Alternate Care spends a great deal of the work day locating respites, out-of-home placements, as well as licensing foster homes and relative homes for children that are not able to remain in the home or community safely. Great efforts and priority are placed on these placement searches and are determined based on fit, well-being, potential reunification success and proximity to the biological home. These child alternate care services were developed to provide for the physical, emotional, and social needs of the child until the child can be reunited with his or her family. When this is not possible, other forms of permanency are utilized such as independent living, various forms of guardianship, adoption and other planned living arrangements (OPLA). It is intended that through respites, short-term placements, regular family interactions, and supportive services, children will be reunited with their families as soon as diminished protective capacities are increased and child and community safety is not at risk. Great measures are taken to work with county, contracted, and kinship placements to form a team concept working toward the goal of successful permanency along with the birth family, extended family, informal and formal providers. In 2015, our foster care coordinator licensed five level 1 and level 2 homes, in addition to licensing four county foster homes to assist in these efforts.

ALTERNATE CARE PHILOSOPHY

- To avoid placements whenever possible, by providing protection, support and services in our communities.
- To work towards permanence for the child from the moment of out-of-home placement. The first choice is often to strengthen the child's family system and reunify that child.
- To keep placements short in duration and make them within the community whenever possible.
- To identify the factors in the family that create unsafe situations, as well as the family strengths and resources to build upon positive pre-existing conditions while dealing with the underlying needs.
- To minimize the use of institutional placements by creating unique community options with providers.

In 2015, the department, through strategic planning, increased contracting and service implementation to decrease our placements in alternate care substantially in a 12 month span. There are many factors that have contributed to the success in the area of child alternate care that span agency wide. First, we continued the focus on increased placement scrutiny through the ongoing placing units such as Juvenile Justice and CPS-Ongoing. Furthermore, Permanency Rountables (PRT's), multi-disciplinary staffings and newly developed contracts with providers focusing on mental health and alcohol and drug issues have aided in our effort to

decrease out-of-home placements. Additionally, our mental health and waiver programs have joined in the agency wide effort to keep children in the home safely with the family systems approach to aid the entire family with superb programming for parents and their children. Finally, the Initial Assessment unit continued the In-Home Safety Services inititiave and Alternative Response approach model in 2015.

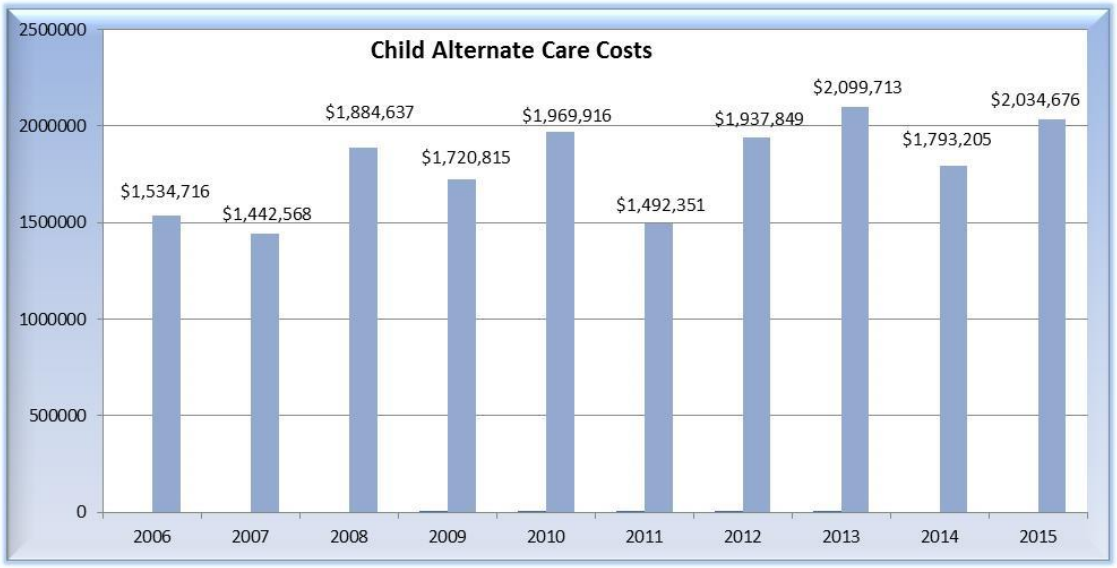
In 2013, Jefferson County referred seven families for In-Home Safety Services in which out-of-home placements for 15 children were prevented and over $96,000 was saved in alternate care costs. In 2014, nine families were referred for In-Home Safety Services in which out-of-home placements for 16 children were prevented and $81,000 was saved in alternate care costs. In 2015, we referred an additonal nine families for In-Home Safety Services in which out-of-home placements for 12 children were prevented and $55,000 was saved in alternate care costs. Jefferson County has saved over $230,000 during our three year involvement in the In-Home Safety Services program allowing 43 children to remain in their biological home that may have been otherwise placed into alternate care.

In 2015, we saw our alternate care number decrease from 105 children in care to 88 children in care due to the aforementioned dedication and service provision. This has been a successful and strategic four year trend that is attributed to the entire agency. Despite the high number of discharges in 2015, Jefferson County was still able to maintain a high commitment to permanency as 90.3% (2014 89.1%) of children that exited care were discharged with a legally recognized form of permanency by the Department of Children and Families (DCF). Once again Jefferson County is far ahead of the state average in terms of discharges to legally recognized forms of permanency.

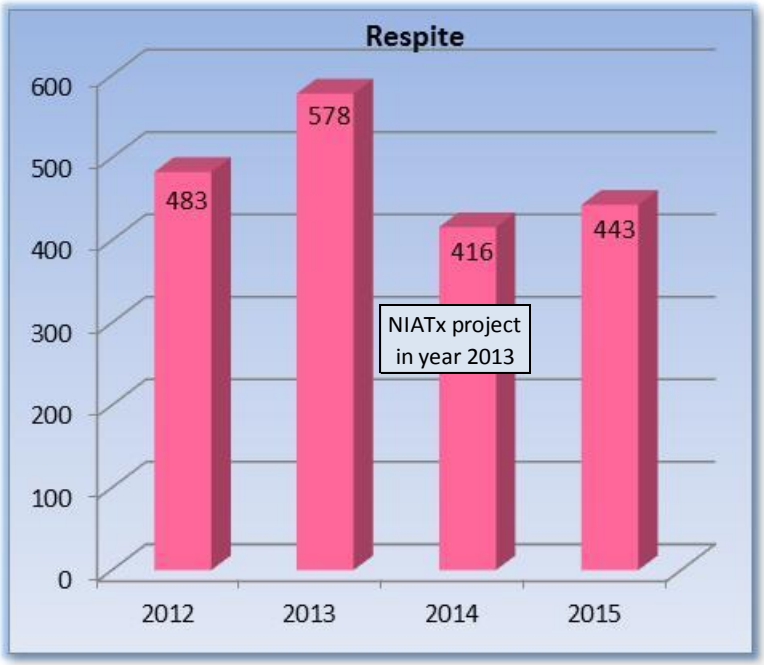
The break down of the various forms of permanence via discharge in Jefferson County in 2015 consisted of the following:

- 47 children or 65.4% were reunified to a parent
- 4 children or 7.7% were discharged due to the department setting up a guardianship
- 9 children or 17.3% were adopted
- 5 children or 9.6% reached the age of majority

Despite our continued decrease in placements the last two years, alternate care spending did increase about 12% in 2015, which is still less than 2013, but not as low as the expenditiures seen in 2014. This slight increase from 2014 to 2015 is due to extraordinary high needs of youth that resulted in higher costing placements such as group homes and residential settings, creating the financial increase. Alternate Care spending is a huge priority and concern for the department each and every year, both fiscally and for child well being. Children and adolescents need permanence, safety, and well being, and while out-of-home placements and multiple placements are necessary to assure safety at times, we know that these situations can be associated with poor lifetime outcomes for children. The department attempts to avoid placements and deter costs in several ways. We have continued to contract with the state to retain legal counsel for situations that require termination of parental rights (TPR). We have increased the number of children on long term support (CLTS) waivers and have implemented parent coaches, peer supports in the home as well as increased community provider contracts to allow children to stay home with services.

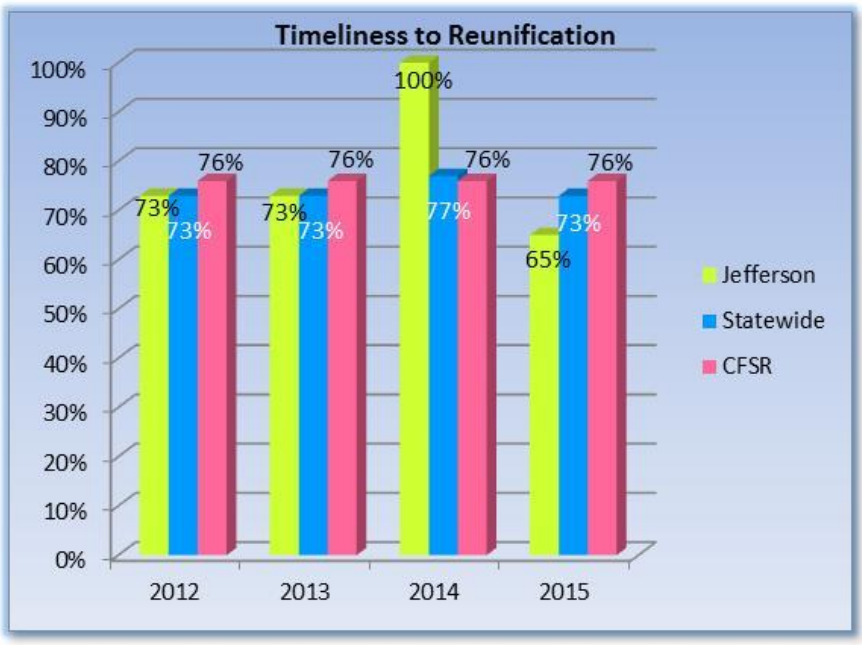


A mechanism that the department utilizes to deter long-term placements is the use of respite. Respite is used to give parents or caretakers a short reprieve. This service is utilized with biological parents to preserve in-home placements, as well as with alternate care providers to preserve difficult out-of-home placements. Jefferson County has a number of formal respite providers that will assist in crisis planning to preserve these placements, but the department has steadily increased the use of family and other informal providers to assist in decreasing this formalized service. In 2015 alterate care provided 228 respite opportunities compared to 518 in 2012. This high number of respites in 2012 was an area of concern that led to a project focusing on the use of respite and implementation of increased scrutiny, additional levels of oversight and the increased use of informal providers. Since the project and implementation of the various strategies we have been able to decrease the use of respite by over 50% from 2012 to 2015.

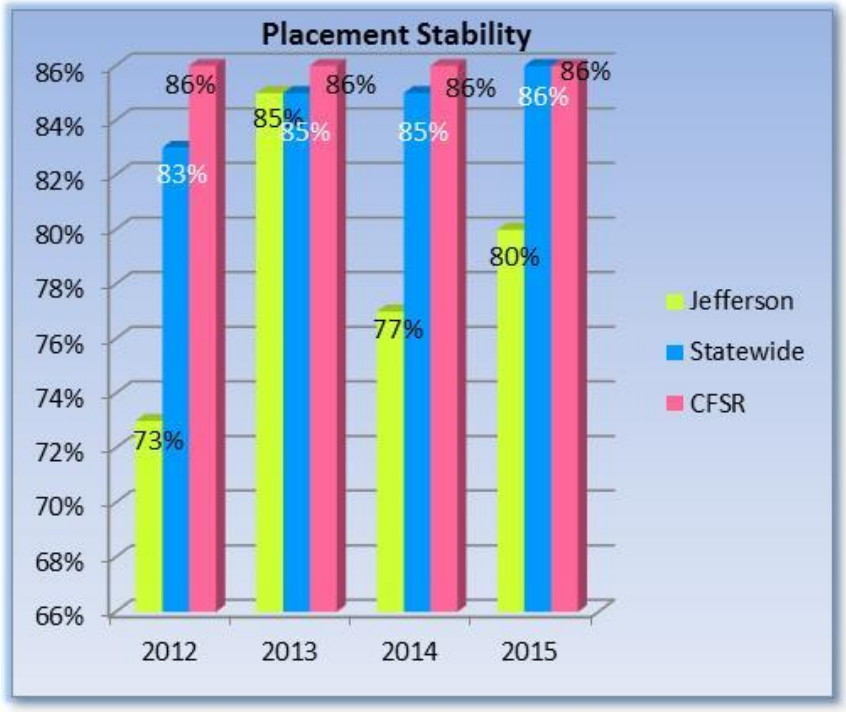


The Department of Children and Families measures each county on a number of placement related performance items which is directly related to the Federal Child and Family Services Review (CFSR). Below is a breakdown of the placement related items:

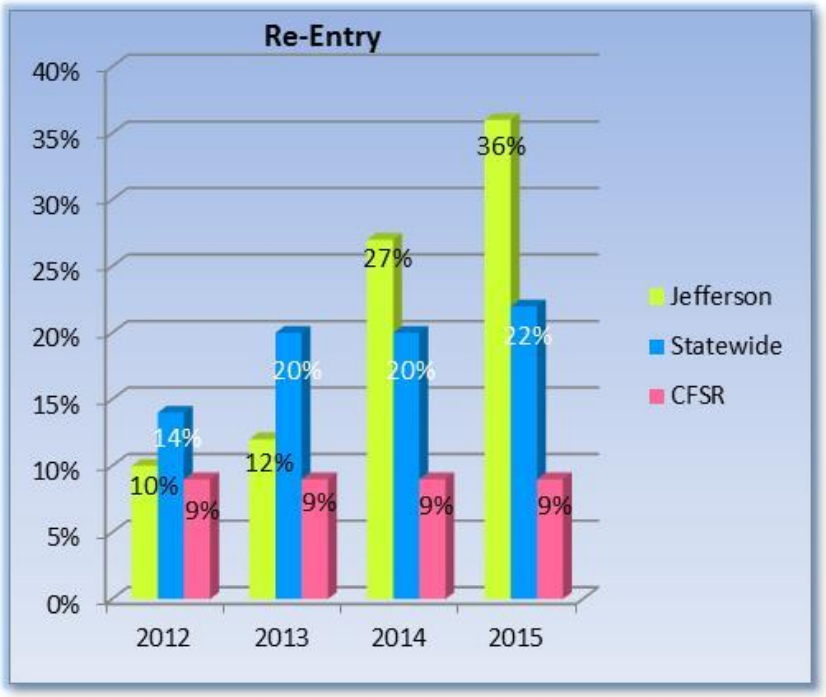
- **Timeliness to reunification** is a federal benchmark that measures discharged children who are returned home. This federal measurement expects that 76.2% or more of children should be returned home within 12 months of placement.



- **Placement stability** is a federal benchmark that indicates that all children placed outside the home for less than 12 months should have no more than two placements during that placement episode. This federal measurement is set at 86% or above.



- **Re-entry into out-of-home care** is a federal benchmark that tracks the re-entry rate of children BACK into care after the discharge from a placement. The federal benchmark is that no more than 8.6% of all children discharged from placement to reunification in the 12-month period prior will re-enter alternate care.



- **Maltreatment in out-of-home care** is a federal benchmark that tracks substantiated abuse to a child by a facility or foster parent while placed in their care at a rate of 0.57% or less. Jefferson county had zero incidents of substaniated abuse of children while in care in 2013, 2014 and 2015 which is better than the federal benchmark and the state average of .14%.

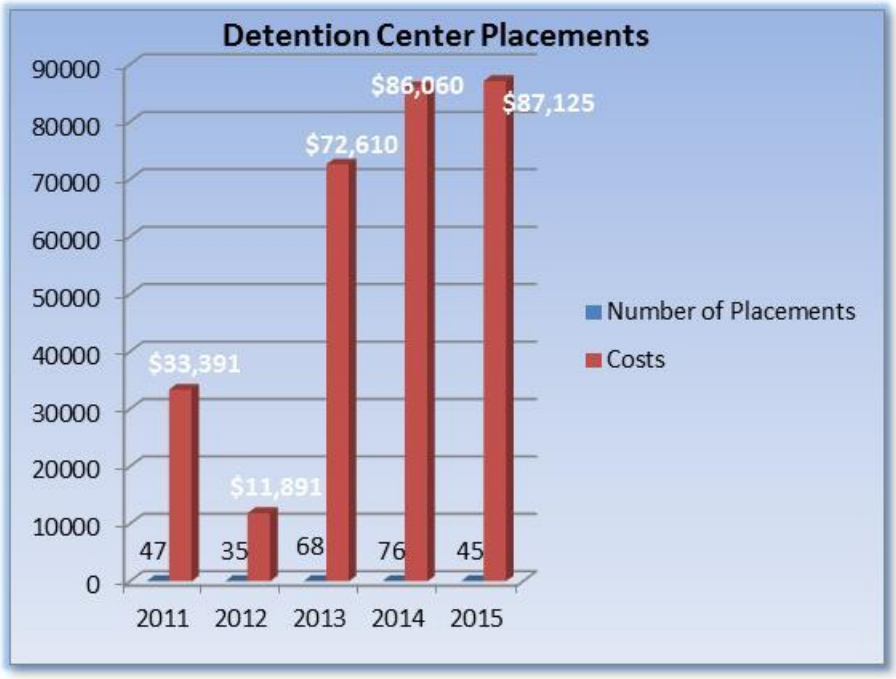
As you can see in the graph below, most individuals requiring placement can be maintained at the foster home level, while others require more restrictive placements such as group home, residential care, or as restrictive setting as we have available, juvenile corrections. As the numbers indicate, we take great measures to avoid these types of highly restrictive settings and utilize those only when community safety cannot be controlled otherwise. Because the needs of children who require alternate care are high, programming efforts, particularly mental health services, are used in conjunction with placements. The following chart exemplifies Jefferson County's placement of youth into some form of out-of-home care from 2010 through 2015. This number represents very short Temporary Physical Custody (TPC) placements all the way to long term placement episodes. Additionally, the number indicates that we have the need for multiple placements per child, due to court ordered changes, moving from more restrictive to less restrictive as the juvenile re-integrates back into the community, as well as placements that are not a quality fit for the child or juvenile, which necessitates a change. In 2015 the alternate care placements were similar to that of 2014 across the board, with the exception of our use of group home settings. As indicated earlier we had an overwhelming number of youth with high needs, but were able to avoid the use of juvenile corrections or a major increase in the use of residential treatment. Rather, our department contracted with various group homes for 1:1 staff to allow our youth to remain in the community while remaining in the least restrictive setting as possible.

Finally, the department experienced 60 new foster care placements in 2015 and we are pleased to share that 25 of those children were placed into relative licensed homes. This is significant as 42% of our children in community care were able to be placed with relatives or providers that had a significant relationship with the child prior to placement. This a positive three year trend that the entire department takes great pride in.

Alternate Care Placements - Children						
SETTING	2010	2011	2012	2013	2014	2015
Foster Care	132	125	130	82	127	112
Residential Treatment Center	18	6	5	2	6	7
Juvenile Corrections	4	3	1	0	0	0
Mental Health Institute	2	1	4	1	3	1
Group Homes	29	12	18	11	13	17
TOTALS	185	147	158	96	149	137

Shelter and Detention Placements

A final statistic that is extremely important to Child Alternate Care is the use of shelter facilities and secure detention for youth. The use of these measures is taken very seriously and secure detention is authorized only as a way of protecting the community and requires supervisor approval at the time of placement. In addition, the use of secure detention can be ordered by the court at a variety of legal proceedings, which occurred from time to time in 2015. Last year 45 youth were placed in detention at the cost of $87,125, while shelter was utilized for 15 youth at the cost of $25,098. This is a dramatic decrease in the number of youth that were placed in detention from previous years as 2014 saw 76 youth in detention. The sharp decrease in detention is the direct result of the many hours that dedicated staff denoted to building community plans and putting safeguards in place with the use of intensive supervision, electronic monitoring, respites, and other deterrents via the case manager and the treatment team. Unfortunately, the department still experienced a number of severe community incidents that required the immediate use of detention and prolonged planning to assure for community safety. As a follow up to last year's report, the use of new, more efficient GPS electronic monitoring also contributed to the decreased placements in detention and shelter, and eliminated the need for these severe measures all together in many instances. The Child and Family Division takes great pride in keeping the community safe, while limiting the use of secure detention.



CHILDREN'S LONG TERM SUPPORT WAIVER

"Helping families support their children with severe disabilities in their own home."

Children's Long Term Support (CLTS) Program Description

The Children's Long Term Support Medicaid Waiver provided services to 97 children. This program provides funding for goods and services to help support and maintain children in the community who have been diagnosed with a developmental, physical or mental health disability. Allowable services are adaptive aids, support and service coordination, children's foster care, communication aids, consumer and family directed supports, consumer education and training, daily living skills training, home modifications, nursing services, respite care, specialized medical and therapeutic supplies, and supportive home care.

Transitioning Medicaid Coverage of Autism Spectrum Disorder Treatment

On July 7, 2014 counties received an informational bulletin from the Department of Health Services regarding the clarification of medicaid coverage of services to children with autism. On September 14, 2015 counties received a summary status update on the transition coverage of autism treatment services from the Children's Long Term Support Waiver Program to the Forward Health Behavior Treatment Benefit. On October 20, 2015 counties received guidance from the State to provide a transparent transition to occur on January 1, 2016. The purpose of this change allows the transfer of autism treatment services currently under the CLTS Waiver Program to a Forward Health Benefit allowing the agency to eliminate the wait list for autism treatment services. Jefferson County collaborated with autism treatment providers to assist with the preparation of transition of nine children. All mandated steps provided by the State were completed with no disruption in services. Beginning January 2016 the behavioral treatment benefit will be available under Forward Health. Families will no longer be required to enroll in the CLTS Waiver Program for children to receive autism treatment services. Instead waiver workers will refer families to behavioral treatment services for their child.

Transition of Family Support Program - FSP to Children's Community Options Program - CCOP

Jefferson County received notice in July 2015, through the governor's budget, that the Family Support Program (FSP) will no longer exist. The Family Support Program supports children who are living at home who have substantial limitations in multiple daily activities as a result of developmental and physical disabilities and/or severe emotional challenges. The FSP program provides families with a coordinated set of strategies to assist them in the provision of support and guidance to their child with a disability while living at home. Support and funding is based on identified needs to achieve prioritized child and family centered outcomes and can cover a wide range of assistance options. Jefferson County received official notice in October of 2015 from the Bureau of Children's Services that effective January 1, 2016; the Family Support Program funding is merging with the portion of Community Options Program allocated to children to form the Children's Community Options Program. In 2016, county agencies will no longer be able to continue a Family Support committee. We were informed that counties may choose to repurpose members or create a new advisory committee. Discussion was held with the Family Support Committee in October 2015 regarding the changes and the committee unanimously agreed to assume the role and the responsibilities of the Children's COP Advisory Committee. As an advisory committee we will review policies and procedures for CCOP funding moving forward.

2015 Wait List and Variance Approvals

CLTS currently has a wait list of 35 children waiting for services compared to 113 in 2014. Whenever waiver resources become available to serve an applicant, the individual who is the next person on the wait list must be offered the opportunity to receive Medicaid Waiver services. In 2015, 27 children were removed from the wait list. The only exceptions to the "first come – first served" standard are persons meeting the crisis criteria for a variance. In 2015 CLTS staff requested nine variances to the DHS for approval. Variance documentation must clearly describe the specific nature of the crisis situation for the individuals involved. These variances

were submitted due to a sudden change in the child's behavior or the child was behaving in a manner that placed the child or the people with whom the child resides with or the community at large at risk of harm. All nine variances received approval.

2015 Quality Assurance On-Site Records Review

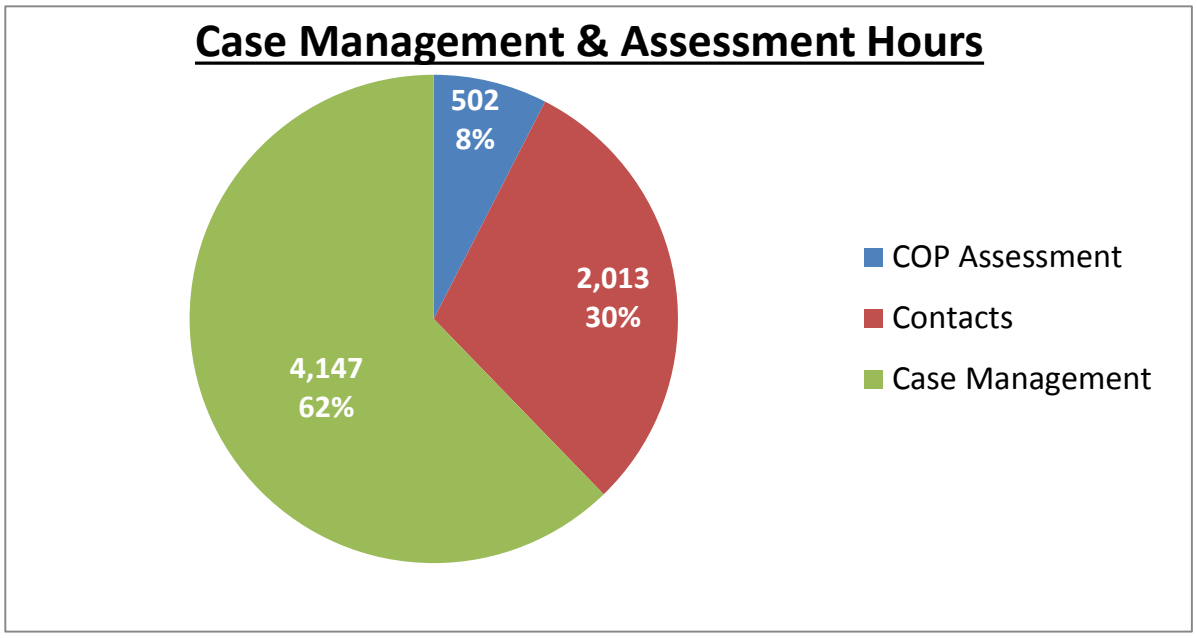
The Department of Health Services gave notice on May 1, 2015 to CLTS that the Quality Service Specialists from The Management Group will be conducting a records review on May 15, 2015. The on-site record reviewers collect quality data that is reported to the Centers for Medicare and Medicaid Services on performance measures and compliance with technical waiver program requirements. On-site record reviews included that requirements are met in the areas of functional eligibility, individual services plans, incident reports, health and safety, and technical compliance with waiver program requirements. Seventeen records were selected from calendar year 2014. We were given a record review tool and a preparation checklist for guidance. Service coordinators and supervisors diligently coordinated files using the record review tools for the on-site review. A phone conference was held on December 16, 2015 for an audit remediation session. During this phone conference Jefferson County learned they will not be receiving any deficiencies or disallowances, as well as received high praise for the outstanding work by the CLTS staff. The Management Group requested additional information in the area of critical incident reporting and suggested the development of information sharing tools for families. The requested information was submitted to the Management Group and on February 2, 2016 Jefferson County received official documentation stating Jefferson County Human Services has successfully completed the 2015 review that looked at compliance requirements.

Carry Over of 2014 Capacity Funds for High Cost Projects

In 2015 service coordinators submitted five high cost projects to DHS. These projects included two van modifications, one bathroom modification, one ramp and two ceiling lifts. Providing these modifications has improved health, safety, accessibility and provides for the maximization of independent functioning for the various children.

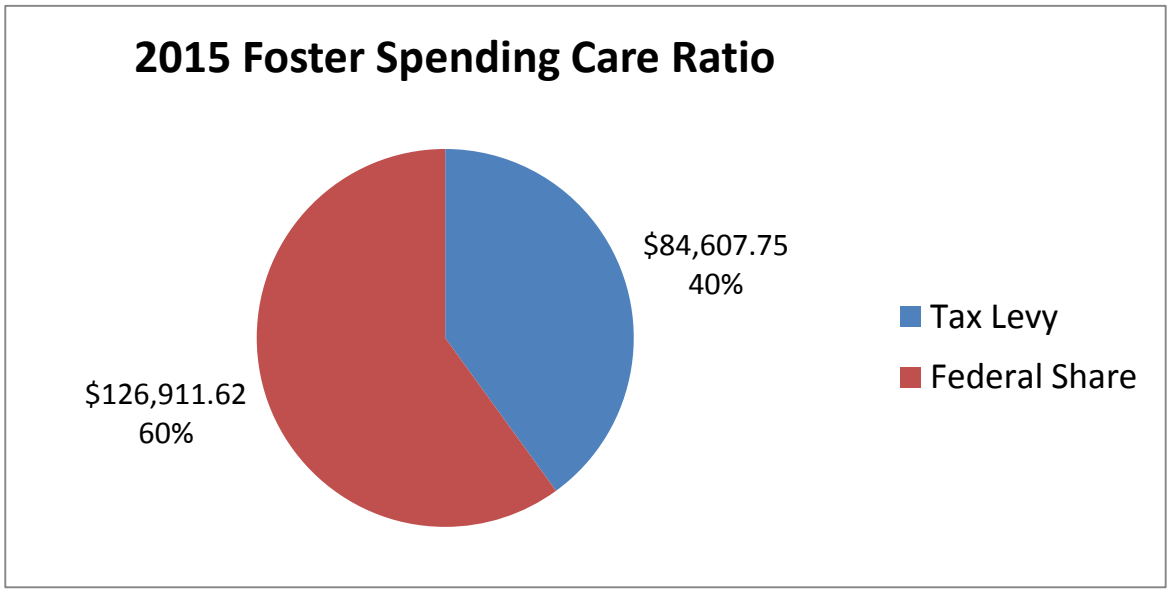
Case (Care) Management Hours and Reimbursement

The below data was collected from the internal Electronic Daily Activity Log (EDAL) system. The Electronic Daily Activity Log is an electronic process for tracking daily activities and work hours. This system monitors service and billable time. Staff are expected to maintain a weekly billable time of 80% or higher. In 2015 Support and Service Coordinators provided 4,147 hours of case management services compared to 2,009 hours in 2014 which is a very dramatic increase directly related to time management efforts focused on reimbursable time. The provision of these services is to locate, manage, coordinate and monitor all waiver program services, any additional services (regardless of funding source) and informal community supports provided to eligible children. Additionally, case management's role is to assure that services are provided in accordance with program requirements. These services are intended to ensure the child's health and safety by enabling the child to receive a full range or appropriate service and supports consistent with the child's assessed needs in a planned coordinated efficient and cost effective manner. The total amount of case management services billed for 2015 was $280,346.64 compared to just $140,808.24 in 2014. Additionally, 502 hours of assessment time was provided to new participants, which were reimbursed through the COP – Community Options Program. In 2015, 2,013 contact hours were conducted by CLTS staff. These contacts are a monthly mandated requirement and the contact is required to pertain to the child's services or be health and safety related. Above and beyond the minimum monthly contacts, 4,147 hours of case management services were provided to the CLTS participants while staff dealt with a wide range of pro-active and crisis related situations. A unique aspect of Jefferson County's CLTS program is the deliberate role staff play as a part of various multi-disciplinary teams for the children outside of DHS requirements.



Foster Care Spending Ratio

Thirteen children who resided in foster care throughout 2015 received Children's Long Term Support services. The total annual cost for these 13 children to reside in out of home placement was a grand total of $211,519.37. Due to the Children's Long Term Support Program, the Federal waiver program financially assisted with $126,911.62, while with county tax levy dollars only paid the remaining $84,607.75. Children in foster care qualifying for CLTS are a cost saving measure to the alternate care budget. Foster parents receive extra support and services to maintain the child in a home environment.



Review of 2015 Goals:

1. **The Key Outcome Indicator for Children's Long Term Support (CLTS) team in 2015 was that 90% of all children involved in services would remain in the home.** 2015 disenrollment data shows (90 out of 95) 94.6% of the children served via the CLTS program were able to remain in the home.

2. Develop and implement an internal policy and procedure for reducing the timeframe from the date of assignment of the referral, through the completion of the functional screen. The total time frame for completion will be 45 days, which will allow families a decreased time sensitive waiting period to obtain the desired services and resources they want for their child. ***This goal was accomplished***. *To accomplish this goal we developed a project with the following Aim Statement: Reduce completion time by 30 days from date of receiving the referral to completion of the functional screen. The Medicaid Waiver Manual states this should be completed in 45 days of referral date. As a team we felt if we could improve this timeframe this would allow families a decreased waiting period to obtain the desired services and resources they want and need for their child. Our team was comprised of our fiscal manager, billing staff and CLTS staff. Through our team we developed a document for tracking dates of referral received, first contact with family, assessment date and assessment completion. The supervisor collected data from 14 files and via the PPS functional screen state system. Data collected revealed that staff met timeframes 10 out of 14 times. The four files that did not meet the 45 day time frame were not met due to the worker being unable to reach the family due to a change in parent's phone or address causing a delay in locating the family.*

3. Program supervisor and staff will expand the pool of service providers by providing education and subsequent outreach to technical colleges, certified nursing assistant or nursing programs, school paraprofessionals, residential programs and agencies. ***This goal was accomplished***. *A presentation was given to the CLTS staff from the director and community services supervisor of Orion Family Services. The Services that Orion can offer to our CLTS families are parental education, mentoring, respite and daily living skills. We are currently in the process of expanding service provision through Orion Services as a result of the presentation. In 2015 Paragon staff and CLTS staff met to discuss how to address the unmet programming needs identified by families, as families have expressed a need for alternative short term respite options. This service would allow families time with other family members or to participate in an activity (movie, dinner out) that they normally would not be able to do. As a result of our interactions Paragon has added a variety of respite options such as Friday night times and three hour options to their respite programming. Additionally, our service provider pool has increased due to outreach with UW Whitewater Student Organizations, St. Coletta's of Wisconsin and school paraprofessionals.*

4. Develop an internal policy for agency approval to meet the state requirements for high cost projects. This policy will encompass the entire process from bid to completion, allowing projects to be completed in a desired time frame to meet the health and safety needs of the child and family. ***This goal was accomplished***. *We implemented a change project and our Aim Statement was to decrease barriers in communication between state and internal and external resources, while clarifying roles in the process. Our change team members were our Children's Services Specialist from the state, JCHSD Fiscal Manager, Maintenance Supervisor and CLTS staff. We developed a protocol checklist and packet to be used as a template prior to submitting the high cost project to the state. CLTS staff will utilize the high cost request protocol checklist and template packet 100% of the time when meeting with the family and contractor. The packet will be reviewed by the team prior to submitting the completed proposal packet to the State.*

5. Develop a tracking system with the Family Support advisory committee using the protocol from the state for determining and prioritizing health and safety needs for families requesting Family Support dollars. ***This goal was accomplished***. *At our March advisory committee meeting we reviewed the current protocol used for the*

equest of Family Support dollars. The advisory committee felt that the policy and procedure that the agency currently has in place is sufficient.

2016 Goals:

Key Outcome Indicator: Six month individual service plans will meet 100% compliance mandates for no disallowances.

1. Develop a family satisfaction survey to distribute to families on an annual basis to measure the quality of practice to improve programming for CLTS families.

2. Provide training for families and providers to inform them of the mandated reporting standards and documentation requirements such as incident reporting and confidentiality.

3. Develop a policy and procedure for internal staff to report critical incidents to CLTS staff in accordance with the Department of Health Services-Division of Long Term care to avoid auditing disallowances.

4. To be in 95% compliance of meeting state mandates of not exceeding 365 days of annual recertification determination date identified on the functional screen.

INDEPENDENT LIVING

~Helping young adults become independent, responsible and productive members of society when they reach adulthood~

Adolescents face a range of developmental issues, and as teens approach adulthood, living independently becomes a significant goal. While youth with intact families may struggle to achieve self-reliance, youth in out-of-home care face formidable obstacles. The Jefferson County Independent Living Skills (ILS) program, which consists of the Division Manager, the program supervisor and one service coordinator, is a partially federally sponsored program for youth 15 ½ to 21 years of age. The youth involved are currently in a court ordered out of home placement, or have attained 16 years of age and have left foster care for kinship guardianship or adoption, or have aged out of care by turning 18 while still in placement. Young people who have aged out of care are offered services akin to case management and are eligible until they are 21, if not enrolled in school, or 23 if enrolled in post-secondary education prior to age 20, have at least a "C" average, and have maintained contact and case management with the Independent Living Service Coordinator. The Jefferson County Independent Living Services (ILS) program served 40 youth/young adults in 2015. That number will grow in 2016, as recent legislation decreased the age of services to 14 in order to better prepare these youth for success after they leave the foster care system. There are different aspects to the program, which are designed to support a successful transition into adulthood.

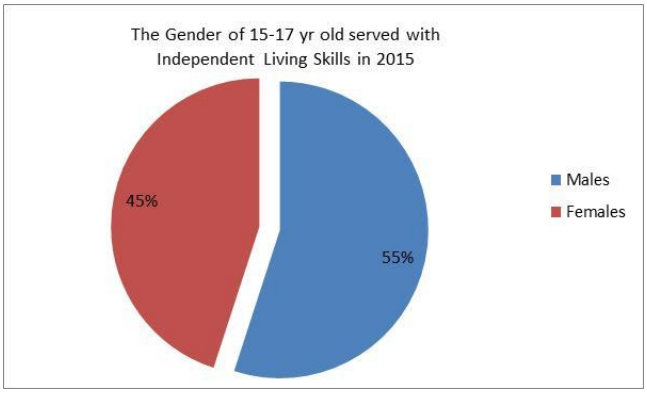
The "John H. Chafee Foster Care Independence Program (CFCIP), part of the ILS program at Jefferson County Human Services Department, offers assistance to help current and former foster care youth achieve self-sufficiency. Activities and programs include, but are not limited to, help with education, employment, financial management, housing, emotional support and assured connections to caring adults for older youth in foster care." In addition to the services listed above, Jefferson County Human Services uses Chafee funds to purchase

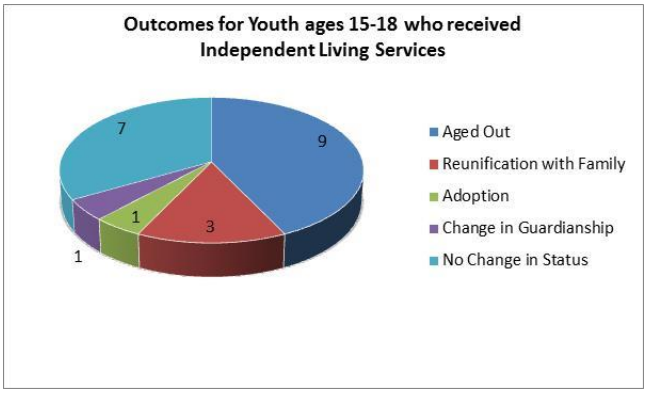
birth certificates for employment, school and driver's license purposes, college application fees, and incentives for completion of goals.

The Educational and Training Vouchers Program (ETV) provides resources specifically to meet the education and training needs of youth aging out of foster care. The ETV aspect of the Independent Living Skills program offers additional dollars for post-secondary educational and training vouchers for youth likely to experience difficulty as they transition to adulthood after the age of 18. This program makes available vouchers of up to $5,000 per year per youth for post-secondary education and training for eligible youth. ETV funds are instrumental in assisting young adults who have aged out of care pay for all or part of their tuition, text books and other items necessary to begin and be successful in a college or career training setting. Students have to remain enrolled in school and maintain a C average or better in order to receive additional funding.

Youth ages 15-17 years

Youth in out-of-home placement, ages 15-17, complete a life skills assessment and develop an individual living transitional plan with the assistance of the Independent Living Services Coordinator. Youth develop personal goals and identify individuals who can assist them in reaching their goals while supporting their transition from a youth to a young adult. Services are provided on an individual basis or when appropriate, in a group setting,. Transition goals are developed by the youth with the assistance of the Independent Living Services Coordinator, ongoing case worker, foster parents or group home provider and the youth's natural supports, such as parents, grandparents, aunts and uncles, cousins, friends, teachers, faith providers, and other community members the youth feels makes a positive difference in his/her life. Progress is monitored by team members on a regular basis. Youth who receive services through the Independent Living Program can be placed in out of home care via a Child Protective Services Court Order or a Juvenile Justice Court Order. There were slightly more males than females who received ILS services in 2015, and the majority of recipients in this age category were in foster care placements, as reflected in the charts below.





PLACEMENT TYPES	2013	2014	2015
Relative	4	4	2
Foster Care	3	9	11
Treatment Foster Care	14	7	4
Group Home	3	13	4
Shelter Care	3	17	4
Residential Care Center	1	8	5
Secure Detention	2	14	1
State Hospital	0	1	0
Missing from out of home care	0	5	3

Youth ages 18-21 no longer in out-of-home care

Young adults ages 18-21 who are no longer in out-of-home care complete a life skills assessment to determine the areas of ongoing need, identify personal goals and develop a transitional discharge plan. The transitional discharge plan incorporates the youth's ongoing needs with their personal goals. The Independent Living Services Coordinator assists the youth with their transitional discharge plan and offers assistance with educational planning, career development, employment, housing, transportation, child care issues, family planning, accessing community resources, managing AODA issues, building healthy relationships, risk prevention as well as other concerns the youth might be experiencing or may be expected to encounter.

Youth Advisory Council

Youth and young adults in the Jefferson County ILS program are encouraged to join the Southern Wisconsin Youth Advisory Council (YAC). The Southern Wisconsin YAC is overseen by the Department of Children and Families Office of Youth Services and is actually managed by Jefferson County. The Youth Advisory Council is designed to give youth in the foster care system a voice and offers wonderful opportunities for these young people to advocate for change in the foster care system. They learn how to be advocates by attending conferences around the state and are given opportunities to testify at legislative hearings and be panel members for professional conferences attended by foster parents, social workers, managers and even judges.

The Southern Wisconsin YAC had a very successful year in 2015. The recipients of the ILS program were offered at least 16 advocacy opportunities. In 2015, various YAC members attended a total of five training events that provided information on how to obtain the tools to live safe, healthy and independent lives. This includes one out of state conference held in Florida. Several members of the YAC became highly involved in the Prudent Parenting legislation on some level, with some members meeting with representatives and testifying at the capitol. YAC membership grew by 50% in 2015, and we would like to expand the council even more in 2016 by doing more outreach to nearby counties in the Southern Region.

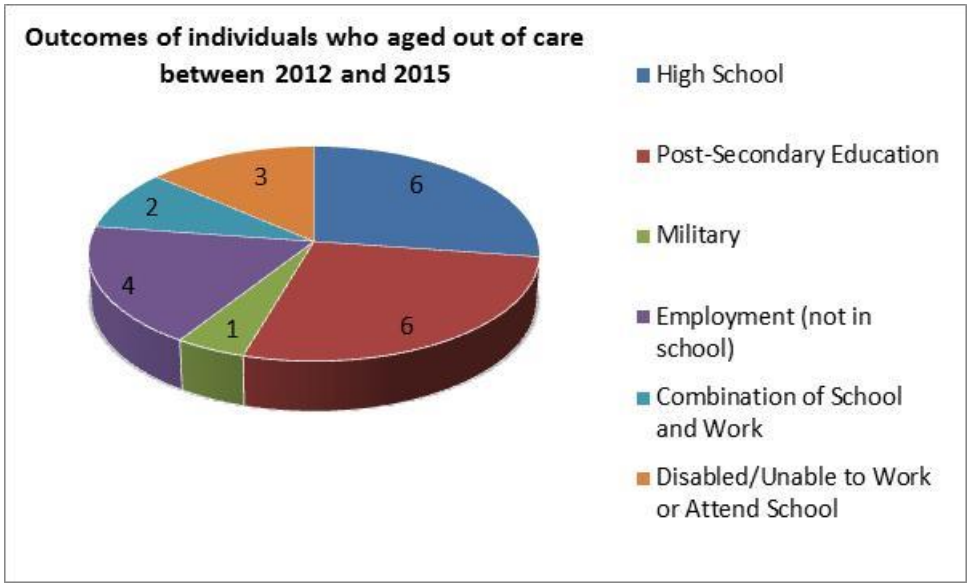
Foster Match Program

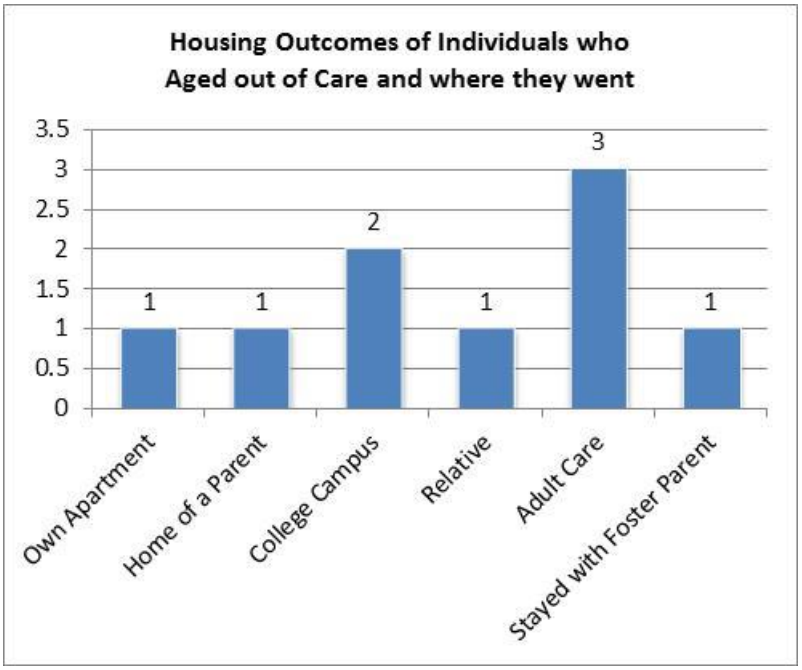
One of the goals of the YAC at its inception was to create a mentoring program that pairs older foster youth or individuals who have aged out of care with younger children and adolescents in out of home placements. Through a lot of hard work and a great partnership with Big Brothers/Big Sisters, this dream became a reality in 2015. The "Foster Match" program offers weekly contact, either through face to face meetings or phone or email contact between "bigs" and "littles." It appears to be highly beneficial for children in care to be able to share their experiences with someone who has been there and healing for older adolescents and young adults who have survived the trauma of being removed from their homes. The program is still in its infancy and we're learning and tweaking as we go. We would like to expand the program next year, offering more matches in Jefferson County and would eventually like to expand the program throughout the state.

Aging out Increases Risk of Homelessness

Though there are differing opinions about actual numbers related to homelessness in young adults who age out of care, all studies that have been completed demonstrated an increased risk. According to a Chapin Hall study that followed 700 people who aged out of care from 2003 until 2011, including participants from Wisconsin and other parts of the Midwest, 36% of those participants had experienced homelessness by the age of 26. In order to track these statistics locally, Jefferson County complies with State and Federal mandates to administer the National Youth in Transition Database (NYTD) to all 17 year old youth in foster care, and 19 and 21 year olds after they age out of care. This program is relatively new, and no long term data has been gathered. However, JCHSD saw this issue first hand in 2015 after three individuals we serve in the Jefferson County ILS program experienced homelessness. Each individual was offered housing assistance by the Independent Living Coordinator, and all three did secure housing with this assistance.

To address a piece of this complex issue, in the spring of 2014 the Legislature passed and the Governor signed 2013 Wisconsin Act 334, which extends out-of-home care and other supports to youth in the child welfare system to age 21 for those youth who are enrolled in school full time under an Individualized Education Program. The new law became effective August 1, 2014. Though we still do not have any consumers who have qualified or requested this service, we are excited about the possibilities it may offer certain individuals in this population. Homelessness in those who age out of care is an issue that we do not take lightly and have addressed it through our Key Outcome Indicator in 2016.





Review of 2015 Goals:

1. **The Independent Living Program's Key Outcome Indicator was that 90% of Independent Living (IL) youth and young adults who have aged out of care will enroll in a military, work program or secondary education program.** This goal was nearly met in 2015, as 83% of the youth and young adults who aged out of care had enrolled in a military, work program or secondary education program.

2. Participation in the Youth Advisory Council (YAC) will increase by 50% in 2015. **This goal was accomplished.** In 2015 we were able to increase the number of youth who participated in at least one YAC meeting in 2015 by 50%. Though all of these individuals originated from Jefferson County, they were placed throughout the State of Wisconsin. We would like to focus our efforts in 2016 to include youth and young adults who do not originate in Jefferson County, specifically targeting Rock and Waukesha counties.

3. Under the supervision and guidance of the Jefferson County ILS program, the Youth Advisory Council will meet a minimum of four times this year to set and work on goals, present speakers on activities, and develop a fiscal budget of expenses they need to achieve these goals. **This goal was accomplished.** In 2015 the Youth Advisory Council met more than four times for planning session; and various members of the Youth Advisory Council attended additional activities as well.

4. The Jefferson County Youth Advisory Council will provide a minimum of four presentations in various forums about challenges youth/young adults of foster care experience, how they conquered these obstacles, what they are doing today to change the system and to develop an open dialogue and community awareness. **This goal was accomplished.** One YAC member in particular was very active in this mission and presented various presentations, panels, webinars, videos and voiceovers. Other members, both current and previous foster youth, participated in presentations at state conferences, staff training events and the foster care appreciation dinner that they coordinated.

5. The ILS Coordinator will provide youth/young adults with a minimum of 16 advocacy opportunities that provide information on how to obtain the tools to live safe, healthy, independent lives. These events are offered throughout the State, County and local communities and allow them to have a voice in their future and develop leadership opportunities. **This goal was accomplished.** In 2015, the recipients of the ILS program were offered at least 16 advocacy opportunities. In 2015, various YAC members attended a total of five training events that provided information on how to obtain the tools to live safe, healthy and independent lives. This includes one out of state conference held in Florida. Several members of the YAC became highly involved in the Prudent Parenting legislation on some level, with some members meeting with representatives and testifying at the capitol.

6. 100% of the youth who receive IL services who are enrolled in a high school educational program will complete all school requirements to move onto the next grade, or if eligible, graduate with a diploma, HSED or GED. **This goal was accomplished.** All of the youth (100%) who receive ILS services either moved onto the next grade level or graduated with a high school diploma.

2016 Goals:

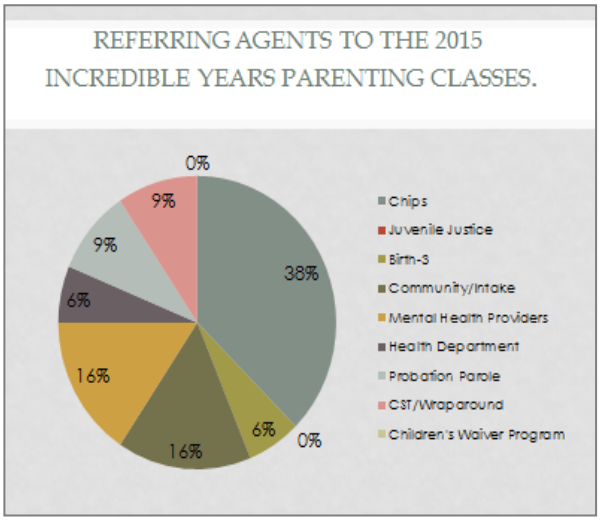
1. **Key Outcome Indicator**: **100% of young adults receiving ILS services who have aged out of care will have safe and stable housing.**
2. 90% of all ILS service recipients will be enrolled in an educational, work or military program.
3. 100% of the youth who receive IL services who are enrolled in secondary educational program will complete all school requirements to move onto the next grade or graduate with a diploma, HSED or GED.
4. Participation in the Youth Advisory Council will increase by 50% in 2016.
5. The "Foster Match" program will increase participation by three additional matches in 2016.
6. The Jefferson County Youth Advisory Council will provide a minimum of four presentations in various forums about challenges youth/young adults of foster case experience, how they conquered these obstacles, what they are doing today to change the system and to develop an open dialogue and community awareness.
7. 100% of young adults who age out of care will be provided services to obtain and maintain safe, stable and affordable housing.

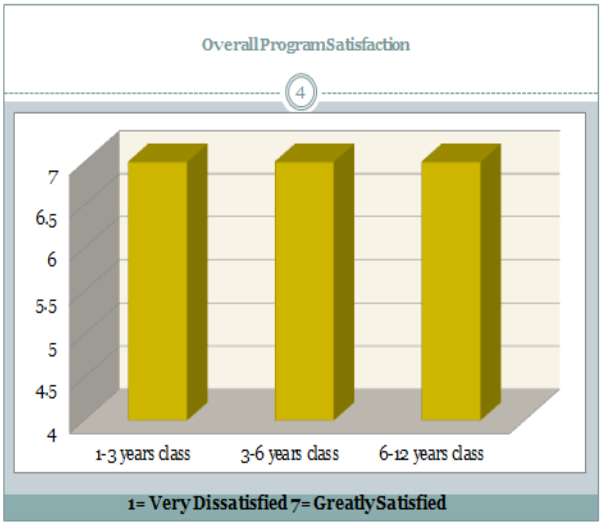
INCREDIBLE YEARS PARENTING PROGRAM

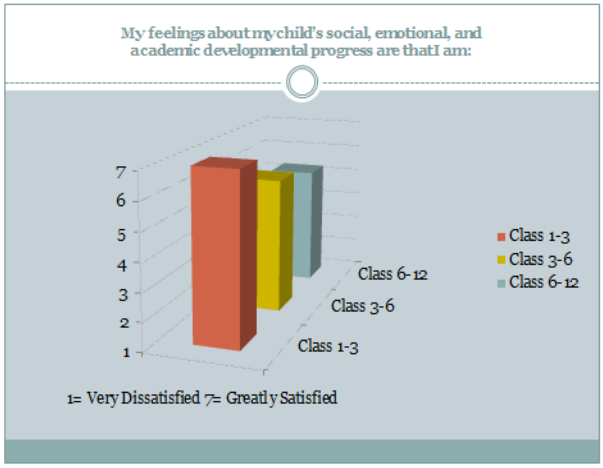
"Classes encourage parents to connect with other parents and enhance parenting skills."

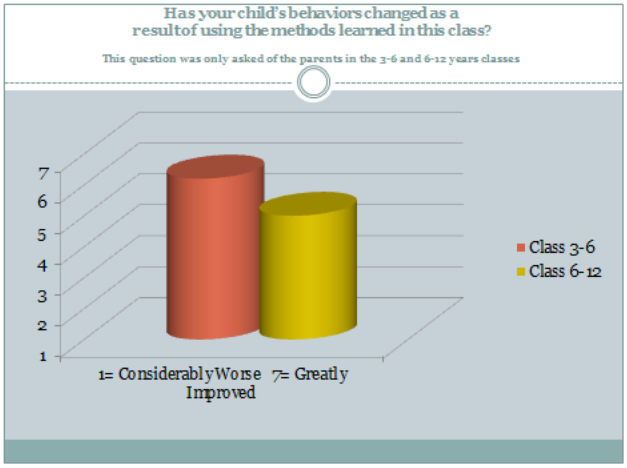
Jefferson County Human Services offers parents, caregivers, guardians and family members the opportunity to participate in the Incredible Years (IY) parenting series. The Incredible Years Program is a comprehensive curriculum designed to promote social competence and prevent, reduce and treat aggression and related problems in babies, toddlers, young children and school aged children. The interventions that make up the series are guided by developmental theory and take into account the role of multiple risk and protective factors. The program strives to improve parent-child interactions by building positive relationships, improving parental functioning by demonstrating less harsh and more nurturing parenting, and increase parental social support and problem solving. This is the only ongoing, evidenced based parenting class offered to families throughout Jefferson County. All classes encourage participants to connect with other parents and enhance parenting skills, use play to build relationships, develop an understanding of developmental stages, limit setting, and increasing the overall joy of parenting. In 2015 we offered three parenting classes targeting the 1-3, 3-6 and 6-12 age groups. All referrals were contacted and offered the opportunity to participate in the class. Some parents declined the opportunity to attend the class due to conflicts with schedules; the age range of the class being offered did not meet their needs, or found other resources that met their needs. In 2015 the IY class was presented to the family court mediator for observation, education and referral purposes. Outreach was also provided through the development of a brochure and PowerPoint for the agency lobby and resource fairs. These parenting classes are funded through tax levy dollars and United Way of Dodge/Watertown and Walworth/Jefferson.

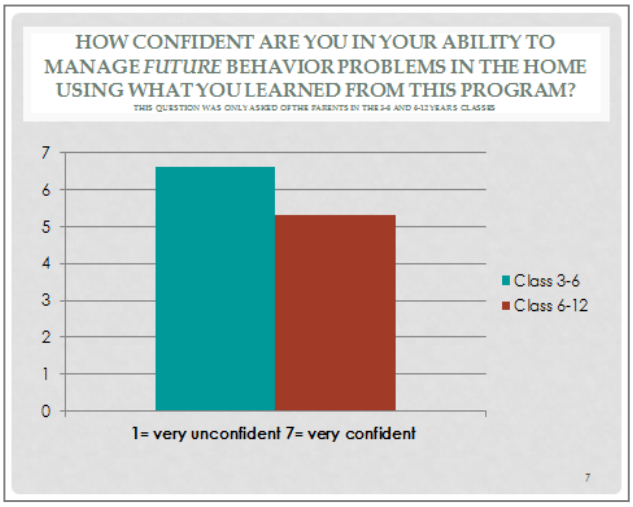
The following graphs summarize the referring agents, satisfaction and program outcomes.

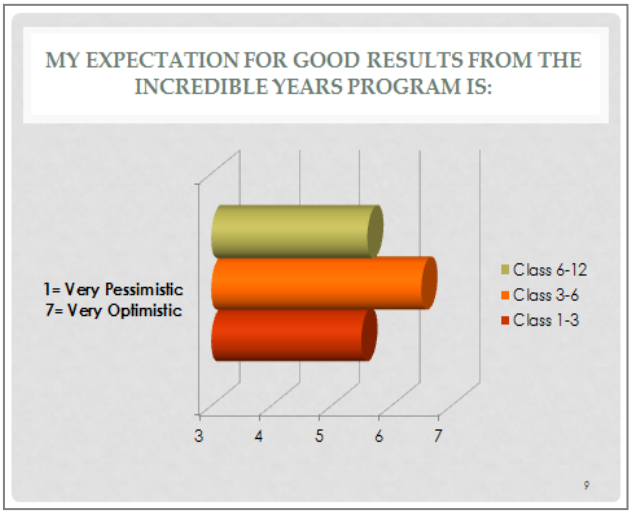












Review of 2015 Goal:

Provide a parenting class to enhance the social and problem solving skills, as well as the emotional literacy, to parents of "At-Risk" children ages four to eight years of age. ***This goal was accomplished****. We provided three classes in 2015 targeting this particular age range. These classes specifically targeted areas of promoting positive behaviors in school age children, reducing inappropriate behaviors and supporting your child's education. While parents were being educated on these topics, the children participated in group activities pertaining to the same target areas. One of the topics that the children focused on was "Parental Attention and Special Time," where the children made a game they could play with their parents. Another topic was, "Problem Solving" where the children made a problem solving keychain that they were able to take home. The children discussed the steps of problem solving by using real scenarios and solutions.*

2016 Goals:

1. Provide a Children's Incredible Years Social Skills Group in a school setting.
2. Expand parenting class opportunities throughout the agency and community to meet the needs of all 2016 parenting referrals.

ECONOMIC SUPPORT DIVISION

"Providing and Coordinating Resources and benefits to Strengthen Families and individuals"

The Economic Support Programs for Jefferson County are administrated at the Workforce Development Center (WDC). Our location at the Workforce Development Center provides staff with the ability to coordinate the services of the on-site providers: Job Service, the Department of Vocational Rehabilitation, Opportunities, Inc., WIOA/WORKSMART Programs and the Jefferson County Economic Development Consortium. Our community partner connections result in greater service coordination. These partners include: Community Action Coalition, Goodwill Industries, Madison College, Local School Districts, People Against Domestic and Sexual Abuse, Food Pantries, Faith Based Organizations, St. Vincent de Paul and Local Employers. Employment services are provided regionally to facilitate coordination for customers who live in one county and are employed in another.

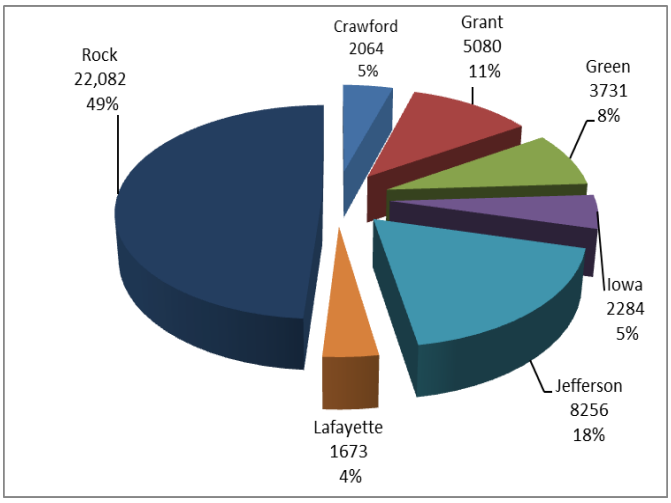
If you are interested in learning more about the current job listings and resources available to meet your workforce needs, the websites of www.wisconsinjobcenter.com and www.worksmartnetwork.org are key sites. The monthly WDC calendars provide employment workshops, skills training and job fairs. In 2015, 13,497 visitors accessed the center's services with an average of 1,125 individuals per month. If you have any questions about services, please contact our office at 920-674-7500.

In December of 2015, our Economic Support Division provided financial assistance to 7,634 Jefferson County households. Customers might receive assistance from Medicaid, BadgerCare, FoodShare or Wisconsin Shares. Eligibility for these services are determined by household income. The current poverty rate for Jefferson County was 11.8% or 9,570 people and the child poverty rate was 16.7% or 3,059 children.

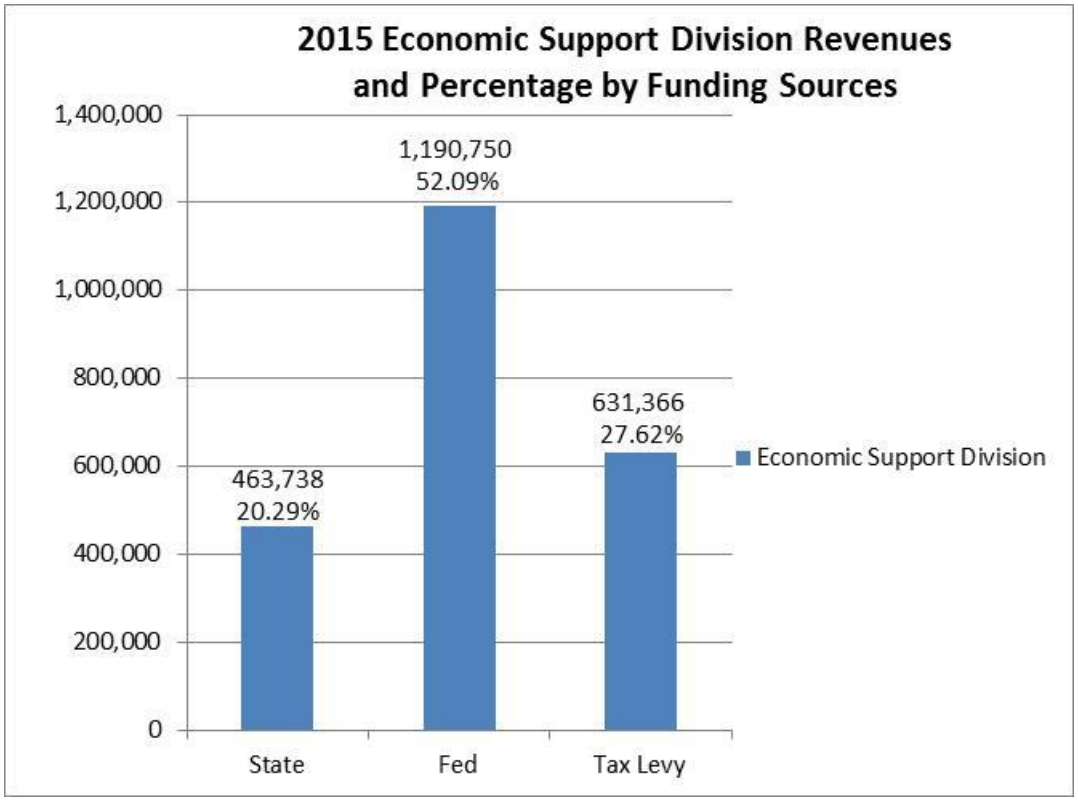
The Economic Support Division of Jefferson County provides residents with access to financial assistance to increase financial stability for households. The Economic Support case managers assist the customers in applying for benefits, determining eligibility, making changes in their situations, explaining program requirements, assessing possible fraud and coordinating referrals to other resources. All Economic Support staff process Healthcare and FoodShare benefits in addition to staff who also specialize in programs such as Child Care, Family Care and Children First. Jefferson County is a member of a seven county group named the Southern Consortium which includes the counties of Crawford, Grant, Green, Iowa, Lafayette, and Rock. The Southern Consortium caseload for December 2015 was 45,170 households with 18% of that the caseload belonging to Jefferson County. Together we coordinate job functions, manage the workload, develop trainings, and implement policies to increase efficiency. One of the main coordinated functions is the Southern Consortium Call Center (SCC). Upon calling the SCC number (1-800-794-5780), the customer has direct contact with an Economic Support case manager from any of these counties who has access to their case information and is readily available to help. Jefferson County has 21 full time Economic Support case managers and 2 administrative assistants who manage these benefits for the households in Jefferson County. The chart shows the Consortium caseload numbers and percentages for December 2015.

Consortium Case Numbers and Percentages

Crawford	2064
Grant	5080
Green	3731
Iowa	2284
Jefferson	8256
Lafayette	1673
Rock	22082



The Division's revenues come from County, State, and Federal funds and is reflected in the graph below. Our funding is directed to Rock County, the lead Consortium Agency, and then disbursed to each county based upon caseload percentage.



Depreciation

County Indirect Cost

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers (County levy).

The Division's overarching goal remains to ENHANCE AND MAINTAIN A SUCCESSFUL INCOME MAINTENANCE CONSORTIUM. The key indicators of our success are measured by our ability to meet timeliness, accuracy and customer satisfaction performance standards established by the State of Wisconsin. Quarterly, monthly and weekly reports specifically addressing each aspect of these key indicators are reviewed and monitored continuously. Accordingly, based upon data obtained, staff trainings and procedural changes are designed to consistently meet these standards.

Following is a brief description of the Economic Support programs and the number of customers who received assistance from these programs in 2015.

ECONOMIC SUPPORT PROGRAMS

The Economic Support Programs serve to improve financial stability for low income households and those experiencing a financial loss. Often our services are necessary to meet an emergency need such as job loss, homelessness, or medical needs. Each program serves a specific population and has different income guidelines and requirements.

Caseloads- December Point in Time

2012 7,177 households receiving assistance
2013 7.384 households receiving assistance
2014 7.731 households receiving assistance
2015 7,634 households receiving assistance

Requests for program assistance can be initiated by contacting the Economic Support Division located at the Workforce Development Center at 920-674-7500 and requesting to speak to an intake worker, coming into the agency, calling the Southern Consortium Call Center at 1-888-794-5780 or applying on line at www.access.wi.gov. The intake case manager is the first point of contact for all the customer's assistance requests. The case manager will assess the customer's needs, coordinate the application process, issue benefits and initiate appropriate referrals to community resources.

SOUTHERN CONSORTIUM CALL CENTER (SCC) - the call center concept began in January of 2012 and is comprised of the Economic Support case managers from seven counties all working together toward common goals. The counties are: Crawford, Grant, Green, Iowa, Jefferson, Lafayette, and Rock. The call center is the focal point for the customer questions, change reporting and application and review processing. In 2015, the Southern Consortium Call Center agents answered and helped 38,204 callers in the first quarter—37,251 callers in the second quarter—38,950 callers in the third quarter and finally 37,750 callers in the fourth quarter for a yearly total of 152,155 calls taken. In 2014, the yearly call total was 132,885 calls with an increase of 19,270 calls in 2015. This was accomplished with an average speed of answer of 2.97 minutes and a call answer rate of 93.13%! The increase in calls received reflects the complicated, consistent changes to our benefit programs as well as the constant changes to our customer's financial situations. The call center agents must meet State established performance standards in the timeliness and number of calls answered, length of call, customer wait time and the accuracy of their benefit processing. The following chart shows the Southern Call Center statistics from October 2014 to December 2015.

Chart 2

SOUTHERN CONSORTIUM CENTER STATISTICS OCTOBER 2014 THRU DECEMBER 2015

Month	Calls Offered	Calls Answered	Answer Rate	Average Speed of Answer/Mins	Average Talk Time/mins	Average Handle Time	Longest Waiting Call /mins
Oct 2014	13954	11758	84.26%	6.17	6.09	6.37	119.65
Nov 2014	11048	10038	90.86%	4.00	6.02	6.30	19.83
Dec 2014	13193	11476	86.99%	4.95	6.02	6.30	19.90
Jan 2015	14041	12472	88.83%	4.49	6.08	6.36	22.10
Feb 2015	11798	11098	94.07%	2.76	5.76	6.04	15.12
March 2015	12365	11852	95.85%	2.05	5.78	6.07	16.88
April 2015	12479	11918	95.50%	2.24	5.67	5.95	17.62
May 2015	11687	10842	92.77%	2.89	5.80	6.08	15.88
June 2015	13085	12255	93.66%	2.72	5.84	6.12	14.85
July 2015	12486	11791	94.43%	2.31	5.87	6.16	13.40
August 2015	13,054	11,979	91.74%	3.30	5.99	6.27	18.12
September 2015	13,410	12,468	92.98%	2.94	5.90	6.18	13.57
October 2015	**13,132**	**12,097**	**92.12%**	**3.47**	**6.20**	**6.48**	**16.85**
November 2015	**11,718**	**10,875**	**92.81%**	**3.26**	**6.49**	**6.77**	**17.27**
December 2015	**12,900**	**11,980**	**92.85%**	**3.29**	**6.36**	**6.65**	**20.08**

MEDICAL ASSISTANCE - is a State and Federally funded program that provides the low income customer comprehensive, affordable healthcare. Numerous individual programs are included in the umbrella of Medical Assistance: BadgerCare , Medicaid, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary, Family Care and Nursing Home programs. Each program has its own specific financial and non-financial criteria for eligibility. The eligible customer receives a Forward Health card which is taken to the health care provider to verify coverage. Most Medical Assistance customers must also participate in a Health Management Organization. At the Medicaid website http://dhs.wisconsin.gov you can access information on the individual program benefits and requirements.

BADGERCARE – is a State and Federal funded healthcare program for low income families, pregnant women, children and childless adults. Eligibility for BadgerCare is determined using IRS tax filing guidelines and household information which is similar to the guidelines used for the Federal Marketplace. If a customer applies at the Marketplace for private health insurance and is potentially eligible for Wisconsin Medicaid their application is routed back to their home county for processing. Conversely, if they applied for Medicaid and are determined to be ineligible their application is automatically transferred to the Marketplace. In the fall of 2015, Automated Case Processing began for healthcare applications. If a household applies on line through ACCESS and the system is able to complete matches for demographic data, income and other data exchanges, the customer's eligibility will be determined immediately.

This chart shows the number of customers on Medicaid programs in Jefferson County since 2011. The total number has remained consistent. In December of 2015, 12,628 individuals were receiving BadgerCare/Medicaid benefits. The bottom graph shows the increase in Medicaid recipients for Jefferson County since 1998.

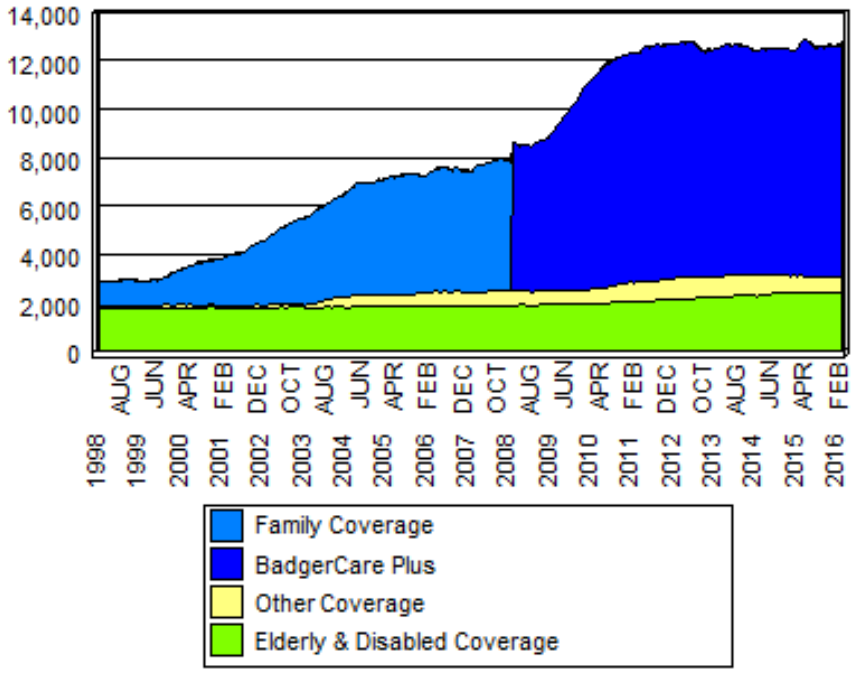
Recipients of Medical Assistance

Caseload on December 31st	Families	Nursing Home	Elderly Disabled	Totals
2011	10,331	243	2.139	12,713
2012	9,983	227	2,191	12,391
2013	9,911	193	2,355	12,459
2014	9,791	171	2,509	12,471
2015	9,905	152	2,571	12,628

Wisconsin Medicaid

Members Certified by County/Tribe and Coverage Type for Each Month and Year

County or Tribe: Jefferson



FOODSHARE-(SNAP) is a Federal Program funded by the USDA that provides a monthly Foodshare allotment to low income customers to purchase food. Eligibility is based upon income, household composition and shelter expenses. The eligible customer receives a QUEST card that is used to purchase food at local grocery stores which supports our local economy. In April of 2015, a change occurred for individuals who are able bodied adults and not currently employed. They are now referred to the FoodShare Employment and Training Progarm (FSET) and work closely with an FSET case manager to obtain stable employment. In December 2015, there were 8,186 FoodShare receipients including 4,545 adults and 3,641 children. The chart below shows the average monthly number of FoodShare customers and the average monthly benefits paid from 2012 to 2015 for Jefferson County. The Foodshare website is http://dhs.wisconsin.gov/foodshare.

FOODSHARE

Year	Average Monthly Recipients	Average Monthly Groups	Average Monthly Total Issuance
2012	9,025	4,063	$961,232
2013	9,025	4,063	$961,232
2014	9,161	4,385	$924,736
2015	8,592	4,170	$851,882

WISCONSIN SHARES-CHILD CARE - is a Federal and State funded program that provides child care subsidies for low income working families to assist in their payment of child care expenses. The subsidy payment is made directly to the child care provider, with the family responsible for the co-payments. Additionally, the Child Care case managers certify in home child care providers, participate in local children's fairs, and present trainings for providers. Specific child care program information can be found at http://dcf.wisconsin.gov/childcare/wishares.

**2014 -249 Households with authorizations for 392 children

**2015- 215 Households with authorizations for 331 children

CHILDREN FIRST- is a State funded program that provides employment case management services for noncustodial parents who are not currently paying their child support. Participation in the program is court ordered. The primary goal of the program is to improve the ability of the parent to pay court ordered child support. The Children First case manager assesses the customer's barriers, assigns activities and connects them to employment resources. Our funding is based upon the number of customers in the county's Child Support caseload and is used to provide financial assistance for their job search activities.

**2014- Case management for 11 non-custodial parents

**2015- Case Management for 5 non-custodial parents.

JEFFERSON ST. VINCENT DE PAUL SOCIETY - provides our division access to local funds for the Jefferson School District customer's emergency needs such as rent and utilities that are unmet by other programs. The household can receive an assistance payment once in a two year time period. Their generosity continues to be greatly appreciated.

**2014- 186 households received $19.804.08

**2015- 179 households received $21,599.97

HOME ENERGY ASSISTANCE- is a Federal and State funded program that provides a single payment during the heating season to low income customers who need help paying their heating costs. The energy payment is made directly to the fuel supplier. Jefferson County continues to contract with Energy Services to administer the program. Energy Assistance Program information can be found at http://homeenergyplus.wi.gov.

**2014- 2,737 Households received $1,171,243 in energy payments

**2014- 215 Households received $118,130 in crisis payments.

**2014-75 Households received $166,685 in heating unit repairs or replacements.

**2015- 2,591 Households received $992,829 in energy payments

**2015-555 Households received $203,604 in crisis payments.

**2015- 54 Households received $96,746 in heating unit repairs or replacements.

FRONT END VERIFICATION AND FRAUD- Focusing upon The Wisconsin Department of Health Services initiative to increase fraud prevention in public assistance programs, Jefferson County has implemented mandated strategies to reduce abuse and fraud of taxpayer dollars. Jefferson County and the Southern Consortium have developed Error Prone Profiles which dictate circumstances when the case manager is required to do enhanced verification or investigation to determine if accurate benefits are being issued. Our division receives approximately 1000 quarterly matches from the State Wage Income Collection Agency (SWICA) to locate unreported income and increases in wages that cause benefit overpayments. The case manager gathers the actual wages from the customer and the employer. Next, they compare the updated wages to the program reporting requirements and previous wages to determine any overpayments. A claim is established and recoupment taken from on-going benefits. If not currently receiving benefits, the customer is responsible to make all required repayments or the individual is referred for IRS action.

In 2015, Jefferson County initiated 63 investigations for potential fraud resulting in $26,526 in overpayment claims and a future savings of $10,511. These overpayments occurred in both FoodShare and Healthcare Programs. We are also able to initiate an Intentional Program Violation (IPV) in a hearing process before an Administrative Law Judge. This hearing sanctions individuals who commit fraud from receiving future benefits for a specific period of time.

THE OVERARCHING GOAL FOR ECONOMIC SUPPORT DIVISION IS TO ENHANCE AND MAINTAIN A SUCCESSFUL INCOME MAINTENANCE CONSORTIUM.

REVIEW OF 2015 GOALS

1. MEET AND EXCEED THE AGENCY MANDATED PERFORMANCE STANDARDS FOR APPLICATIONS, REVIEWS, AND DOCUMENT PROCESSING.
Key Outcome Indicator-To process applications within 30 days of receipt 95% of the time, and reviews and other documents before the end of the month that it is due 95% of the time.

**Southern Consortium processed applications at 96.17%
**Jefferson County processed applications at 98.08%
**Southern Consortium processed reviews at 97.77%

2. THE SOUTHERN CONSORTIUM CALL CENTER WILL MEET AND EXCEED THE MANDATED PERFORMANCE STANDARDS
Key Outcome Indicator- The Southern Consortium Call Center will answer 100% of all incoming calls within 12 minutes.

**Southern Consortium took 152,155 calls in 2015.
**Southern Consortium answer rate is 93.13%
**Statewide average answer rate for December 2015 was 87.02%
**Southern Consortium had the highest answer rate of the 11 consortiums for 3 of the last 6 months of 2015.
**Southern Consortium average speed of answer was 2.97 minutes.
**Statewide average speed of answer for December 2015 was 5.71 minutes.

3. THE REGIONAL ENROLLMENT COORDINATOR WILL CONTINUE TO EXPAND THE ENROLLMENT NETWORK AND ACTIVITIES
Key Outcome Indicator-To lower the percentage of uninsured residents in Jefferson County through MarketPlace enrollment sites, news releases, educational outreach and a coordinated steering committee.
In the spring of 2015, we partnered with the Wisconsin Association for Free and Charitable Clinics to reach more MarketPlace customers. Monthly or bi-monthly enrollment events were held at five local libraries where assistance was available from trained insurance agents. Flyers were distributed with the dates and sites of assistance and monthly press releases were done on relevant healthcare topics. The Economic Support Division continues to have a trained Certified Application Counselor available to assist with Marketplace applications.

*2015 Uninsured rate in Jefferson County was 7%
*2013 Uninsured rate in Jefferson County was 11%

4. MAINTAIN AND DEVELOP ADDITIONAL SYSTEMS TO CONTACT THE CUSTOMERS PRIOR TO CLOSURE OF BENEFITS.
Key Outcome Indicator- To successfully have the customer return needed documents timely 100% of the time to prevent closure of benefits.
In 2015, we planned to increase the amount of phone contacts made reminding the customer of pending verifications to prevent case closures.
We continue to send duplicate verification requests by the 10th of each month. As we were developing our internal process, DHS provided insight to upcoming changes, including text messages and e-mails to the customer's reminding them of what it due and FoodShare on Demand processing which is an immediate action taken when a customer contacts the call center or submits an ACCESS application or review. No further

internal changes were made or measured because the new State process should reduce customer delays. We will evaluate after full implementation.

5. DEVELOP AND MAINTAIN CONSISTENT METHODS FOR STAFF TRAINING. Key Outcome Indicator- To provide staff with the needed materials and resources to process benefits accurately and timely 100% of the time.

In 2015, State staff completed approximately 168 second party case reviews for Jefferson County, checking for completeness and accuracy in benefits. We had 10 cases with errors; 5 technical and 5 income for a 5% error rate. Currently we have bi-weekly scheduled staff meetings to learn and discuss policy changes. Last fall, the Southern Consortium trainer began providing consortium wide trainings through on site presentations, shared desk aids, and bi-weekly all staff consortium interactive meetings. This live connection encourages participation, assures that all staff are learning the same policy information, and provides answers quickly.

2016 GOALS

1. Key Outcome Indicator- To process applications within 30 days of receipt 95% of the time and reviews and other documents before the end of the month due 95% of the time.

* 100% of applications will be processed within 30 days of receipt.
* 100% of reviews will be processed before the end of the month in which they are due, even if customer submits late.
* All documents will be scanned within one week of receipt. Move toward full scan first processing.

These indicators are measured by Income Maintenance Management Reports, Quality Assurance case reviews and CARES system dashboard and work items.

2. Key Outcome Indicator- The Southern Consortium Call Center will answer 100% of the incoming calls in 10 minutes.

DHS has reduced the call center response time from 12 to 10 minutes.

*Customer requests for on demand interviews will be done immediately on the call center.
*Additional agent coverage and teams will be developed to meet the lower call center answer rate.

These indicators are measured by daily/weekly agent activity, consortium developed performance reports, call center statistics, and individual agent Quality Assurance Reviews.

3. Key Outcome Indicator- To provide and promote health insurance literacy for Jefferson County residents with developed health literacy materials.

*Partner with Covering Wisconsin.
*Participate in community outreach events.
*Coordinate with local school districts.
*Coordinate with local libraries.
*Develop WDC workshop on health insurance literacy.

The success of the health insurance literacy project will be measured by the number of events developed, attendance at the events and customer surveys.

4. Key Outcome Indicator- The FoodShare On Demand applications and reviews will be processed immediately or within 2 days of receipt 100% of the time.

*ACCESS applications will be contacted and processed by a case manager within 48 hours.

*ACCESS reviews will be contacted and processed by a case manager with 48 hours.
*Case manager's offices will be moved to increase coordinated responses.
*Caseloads will be merged into case management teams.
*Increased monitoring for effective call center agent coverage.
These indicators are measured by Income Maintenance Management Reports, Quality Assurance reviews, call center statistics and targeted consortium reports.

Change is a constant for all of the Economic Support Programs and a constant thatwe have learned to accept and embrace. In 2016, we will be changing the case management structure that has always been the basis for our program determinations. Customers will no longer have their own case managers. Case managers and customers will be assigned to teams and all eligibility determinations, processing and communication will be accomplished by the teams. Additionally, customers will now be able to contact the Southern Consortium Call Center and immediately complete their required interviews. These changes will benefit both the customer and the case managers by providing greater customer service, increased efficiency, and stronger coordination for the case managers.

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Maintenance, *Terry Gard*

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Comprehensive Community Services, *Tiffany Congdon*

Emergency Mental Health, *Kim Propp*

Mental Illness/AODA, *Holly Pagel*

Lueder House, *Terri Jurczyk*

Medical Director, *Mel Haggart, M.D. – (Contracted)*

Carol Mertins, APNP **–** *(Contracted)*

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Child Welfare*, Kevin Reilly*

Juvenile Justice Integrated Services, *Jessica Godek*

Birth to Three, Busy Bees Preschool, *Beth Boucher*

CLTS/Wraparound, *Barb Gang*

- **Economic Support Division Manager, *Jill Johnson***

Sandy Torgerson, Supervisor

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INFORMATION & ACKNOWLEDGEMENTS

If you have any questions regarding anything in this report or you know someone who is in need of our services, please contact us at the following address:

JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
1541 Annex Rd, Jefferson, WI 53549
Phone Number: 920-674-3105
Fax Number: 920-674-6113
TDD Number: 920-674-5011
Website: www.jeffersoncountywi.gov

AGING & DISABILITY RESOURCE DIVISION
1541 Annex Rd, Jefferson, WI 53549
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Toll Free: 1-866-740-2372

ECONOMIC ASSISTANCE
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Fax Number: 920-674-7520

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